SURGERY

USER MANUAL

Version 3.0
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Department of Veterans Affairs
VistA Health Systems Design & Development

Revision History

Each time this manual is updated, the Title Page lists the new revised date and this page describes the changes. If the Revised Pages column lists "All," replace the existing manual with the reissued manual. If the Revised Pages column lists individual entries (e.g., 25, 32), either update the existing manual with the Change Pages Document or print the entire new manual.

Date	Revised Pages	Patch Number	Description
08/06	6-9, 14, 109-112, 122-124, 141-149, 151-152, 176, 178-180, 180a-b, 181-184, 184a-d, 185-186, 218-219, 326-327, 327a-d, 328-329, 373, 377, 449-450, 452-456, 459, 461-462, 467-468, 468b, 469-470, 470a, 473-474, 474a-474b, 475, 477, 481-486, 486a-b, 489-502, 502a-b, 503-504, 509-512	SR*3*153	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. Updated data entry options to incorporate renamed/new Hair Removal documentation fields. Updated the Nurse Intraoperative Report and Quarterly Report to include these fields. For more details, see the *Surgery NSQIP/CICSP Enhancements 2006 Release Notes.* (M. Montali, PM; S. Krakosky, Tech Writer)
06/06	28-32, 40-50, 64-80, 101-102	SR*3*144	Updated options to reflect new required fields (Attending Surgeon and Principal Preoperative Diagnosis) for creating a surgery case. (M. Montali, PM; S. Krakosky, Tech Writer)
06/06	vi, 34-35, 125, 210, 212b, 522a-b	SR*3*152	Updated Service Classification screen example to display new PROJ 112/SHAD prompt. This patch will prevent the PRIN PRE-OP ICD DIAGNOSIS CODE field of the Surgery file from being sent to the Patient Care Encounter (PCE) package. Added the new *Alert Coder Regarding Coding Issues* option to the Surgery Risk Assessment Menu option. (M. Montali, PM; S. Krakosky, Tech Writer)
04/06	445, 464a-b, 465, 480a-b	SR*3*146	Added the new *Alert Coder Regarding Coding Issues* option to the Assessing Surgical Risk chapter. (M. Montali, PM; S. Krakosky, Tech Writer)

Date	Revised Pages	Patch Number	Description
04/06	6-8, 29, 31-32, 37-38, 40, 43-44, 46-48, 50, 52, 65-67, 71-73, 75-77, 79, 100, 102, 109-112, 117-120, 122-123, 125-127, 189-191, 195b, 209-212, 212a-h, 219a, 224-231, 238-242, 273-277, 311-313, 315-317, 369, 379- 392, 410, 449-464, 467-468, 468a-b, 469-470, 470a, 471-474, 474a-b, 475-479, 479a-b, 480, 483-484, 489-502, 507, 519	SR*3*142	Updated the data entry screens to reflect renaming of the Planned Principal CPT Code field and the Principal Pre-op ICD Diagnosis Code field. Updated the *Update/Verify Procedure/Diagnosis Coding* option to reflect new functionality. Updated Risk Assessment options to remove CPT codes from headers of cases displayed. Updated reports related to the coding option to reflect final CPT codes. For more specific information on changes, see the *Patient Financial Services System (PFSS) – Surgery Release Notes* for this patch. (M. Montali, PM; S. Krakosky, Tech Writer)
10/05	9, 109-110, 144, 151, 218	SR*3*147	Updated data entry screens to reflect renaming of the Preop Shave By field to Preop Hair Clipping By field. (M. Montali, PM; S. Krakosky, Tech Writer)
08/05	10, 14, 99-100, 114, 119-120, 124, 153-154, 162-164, 164a-b, 190, 192, 209-212f, 238-242	SR*3*119	Updated the Anesthesia Data Entry Menu section (and other data entry options) to reflect new functionality for entering multiple start and end times for anesthesia. Updated examples for Referring Physician updates (e.g., capability to automatically look up physician by name). Updated the PCE Filing Status Report section. (J. Podolec, PM; B. Manies, Tech Writer)
08/04	iv-vi, 187-189, 195, 195a-195b, 196, 207-208, 219a-b, 527-528	SR*3*132	Updated the Table of Contents and Index to reflect added options. Added the new *Non-OR Procedure Information* option and the *Tissue Examination Report* option (unrelated to this patch) to the Non-OR Procedures section.
08/04	31, 43, 46, 66, 71-72, 75-76, 311	SR*3*127	Updated screen captures to display new text for ICD-9 and CPT codes.

Date	Revised Pages	Patch Number	Description
08/04	vi, 441, 443, 445-456, 458-459, 461 463, 465, 467-468, 468a-b, 469-470, 470a-b, 471, 473-474, 474a-b, 474-479, 479a-b, 480-486, 486a-b, 519, 531-534	SR*3*125	Updated the Table of Contents and Index. Clarified the location of the national centers for NSQIP and CICSP. Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software and new options have been added. For an overview of the data entry changes, see the *Surgery NSQIP/CICSP Enhancements 2004 Release Notes.* Added the *Laboratory Test Result (Enter/Edit)* option and the *Outcome Information (Enter/Edit)* option to the *Cardiac Risk Assessment Information (Enter/Edit)* menu section. Changed the name of the *Cardiac Procedures Requiring CPB (Enter/Edit*) option to *Cardiac Procedures Operative Data (Enter/Edit)* option. Removed the *Update Operations as Unrelated/Related to Death* option from the *Surgery Risk Assessment Menu*.
08/04	6-10, 14, 103, 105-107, 109-112, 114-120, 122-124, 141-152, 218-219, 284-287, 324, 370-377	SR*3*129	Updated examples to include the new levels for the Attending Code (or Resident Supervision). Also updated examples to include the new fields for ensuring Correct Surgery. For specific options affected by each of these updates, please see the *Resident Supervision/Ensuring Correct Surgery Phase II Release Notes.*
04/04	All	SR*3*100	All pages were updated to reflect the most recent Clinical Ancillary Local Documentation Standards and the changes resulting from the Surgery Electronic Signature for Operative Reports project, SR*3*100. For more information about the specific changes, see the patch description or the *Surgery Electronic Signature for Operative Reports Release Notes*.

(This page included for two-sided copying.)

Using Screen Server

This section provides information about using the Screen Server utility with the Surgery software.

Introduction

Screen Server is a screen-based data entry utility. It allows the user to display and select data elements for entering, editing, and deleting information. The format is designed to display a number of data fields at one time on a menu. With Screen Server, a number of data elements are displayed at one time on a menu and the user is able to choose on which element to work.

This section contains a description of the Screen Server format and gives examples of how to respond to the unique Screen Server prompts. The screen facsimiles used in the examples are taken from the Surgery software; however, these screens may not display on the terminal monitor exactly as they display in this manual, because the Surgery package is subject to enhancements and local modifications. In this document, the different ways to respond to the Screen Server prompt, to perform a task, and to utilize shortcuts are explained. The shortcuts are listed below:

- Enter data
- Edit data
- Move between pages
- Enter/edit a range of data elements
- Multiples
- Multiple screen shortcuts
- Word processing

The user should be familiar with VistA conventions. In the examples, the user's response is presented in bold face text.

Navigating

The user can press the Return key to move through a prompt and go to the next page or item. To return directly to the *Surgery Menu* options, the user can enter an up-arrow (^), unless he or she is in a multiple field. To exit a multiple field, enter two up-arrows (^^).

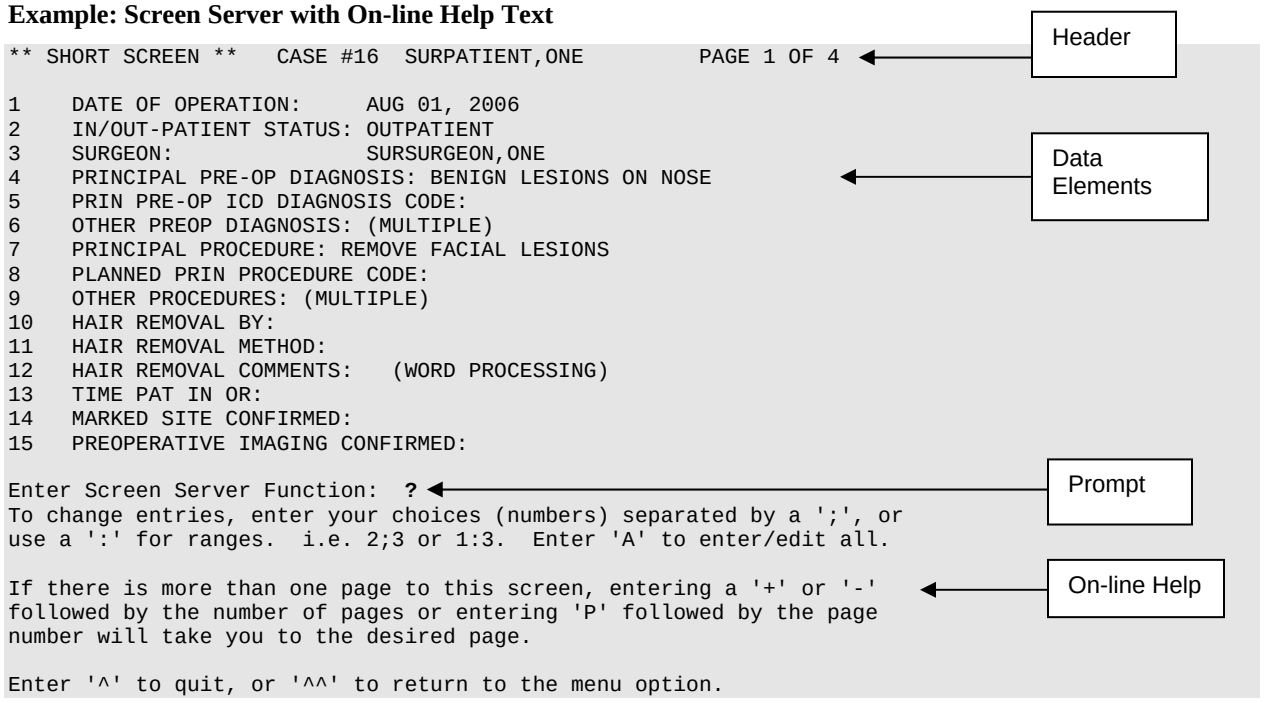
Basics of Screen Server

Each Screen Server arrangement consists of three basic parts: a header, data elements, and an action prompt. These items are defined in the following table.

Term	Definition
Header	The screen heading contains information specific to the record with which you are working. This can include the patient name or case number. The information in the heading is programmed and cannot be easily changed.
Data Elements	Each Screen Server display contains from 1 to 15 data elements (or fields). If information has been entered for any of the data elements defined, it will display to the right of the element. Some data elements are multiple fields, meaning they can contain more than one piece of information. These multiple fields are distinguished by the word "Multiple" next to the data element. If the multiple field contains information, the word "Data" will be next to the data element.
Prompt	The action prompt is at the bottom of each screen. From the prompt "Enter Screen Server Functions:" you can enter, edit, or delete information from the data elements. The possible responses to this prompt are explained in more detail on the following pages. Enter a question mark (?), for help text with possible prompt responses.

The following is an example of a Screen Server display with help text.

Example: Screen Server with On-line Help Text




```
** SHORT SCREEN **   CASE #16  SURPATIENT,ONE         PAGE 1 OF 4

1    DATE OF OPERATION:     AUG 01, 2006
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,ONE
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE:
9    OTHER PROCEDURES: (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:
14   MARKED SITE CONFIRMED:
15   PREOPERATIVE IMAGING CONFIRMED:

Enter Screen Server Function:  ?
To change entries, enter your choices (numbers) separated by a ';', or
use a ':' for ranges.  i.e. 2;3 or 1:3.  Enter 'A' to enter/edit all.

If there is more than one page to this screen, entering a '+' or '-'
followed by the number of pages or entering 'P' followed by the page
number will take you to the desired page.

Enter '^' to quit, or '^^' to return to the menu option.
```

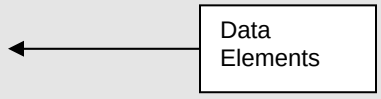
Entering Data

To enter or edit data, the user can type the item number corresponding with the data element for which he/she is entering information and press the **<Enter>** key. In the following example, we typed the number 10 at the prompt and pressed the **<Enter>** key. A new prompt appeared allowing us to enter the data. The software immediately processed this information and produced an updated menu screen and another action prompt.

```
 ** SHORT SCREEN **   CASE #16  SURPATIENT,ONE         PAGE 1 OF 4

1    DATE OF OPERATION:     AUG 01, 2006
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,ONE
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE:
9    OTHER PROCEDURES: (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:
14   MARKED SITE CONFIRMED:
15   PREOPERATIVE IMAGING CONFIRMED:

Enter Screen Server Function:  13
Time Patient In the O.R.:  13:00   AUG 1, 2006 AT 13:00
```

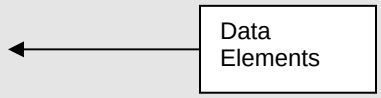


The software processes the information and produces an update.

```
 ** SHORT SCREEN **   CASE #16  SURPATIENT,ONE         PAGE 1 OF 4

1    DATE OF OPERATION:     AUG 01, 2006
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,ONE
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE:
9    OTHER PROCEDURES: (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:          AUG 1, 2006 AT 13:00
14   MARKED SITE CONFIRMED:
15   PREOPERATIVE IMAGING CONFIRMED:

Enter Screen Server Function:
```



Editing Data

Changing an existing entry is similar to entering. Once again, the user can type in the number for the data element he/she wants to change and press **<Enter>**. In the following example, the number 3 was entered to change the surgeon name. A new prompt appeared containing the existing value for the data element in a default format. We entered the new value, "SURSURGEON,TWO." The software immediately processed this information and produced an updated screen.

```
** SHORT SCREEN **   CASE #16  SURPATIENT,ONE         PAGE 1 OF 4

1    DATE OF OPERATION:     AUG 01, 2006
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,ONE
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE:
9    OTHER PROCEDURES: (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:          AUG 1, 2006 AT 13:00
14   MARKED SITE CONFIRMED:
15   PREOPERATIVE IMAGING CONFIRMED:

Enter Screen Server Function:  3
SURGEON:  SURSURGEON,ONE // SURSURGEON,TWO
```

Data Elements

The software processes the information and produces an update.

```
 ** SHORT SCREEN **   CASE #16  SURPATIENT,ONE         PAGE 1 OF 4

1    DATE OF OPERATION:     AUG 01, 2006
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,TWO
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE:
9    OTHER PROCEDURES: (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:          AUG 1, 2006 AT 13:00
14   MARKED SITE CONFIRMED:
15   PREOPERATIVE IMAGING CONFIRMED:

Enter Screen Server Function:
```

Data Elements

Turning Pages

No more than 15 data elements will fit on a single Screen Server formatted page, but there can be as many pages as needed. Because many screens contain more than one page of data elements, the screen server provides the ability to move between the pages. Pages are numbered in the heading. To go back one page, enter minus one (-1) at the action prompt. To go forward, enter plus one (+1) or press **<Enter>**. The user can move more than one page by combining the minus or plus sign with the number of pages needed to go backward or forward.

Entering or Editing a Range of Data Elements

Colons and semicolons are used as delineators for ranges of item numbers. This allows the user to respond to two or more data elements on the same page of a screen at one time. Typing a colon and/or semicolon between the item numbers at the prompt tells the software what elements to display for editing.

Colons are used when the user wants to respond to all numbers within a sequence (for example, 2:5 means items 2, 3, 4, and 5). Semicolons are used to separate the item numbers for non-sequential items (e.g., 2;5;9;11 means items 2, 5, 9 and 11). To respond to all the data elements on the page, enter "A" for all.

Example 1: Colon

```
  ** STARTUP **   CASE #24  SURPATIENT,TWO            PAGE 2 OF 3

1    VALID ID/CONSENT CONFIRMED BY:
2    MARKED SITE CONFIRMED: YES
3    PREOPERATIVE IMAGING CONFIRMED: IMAGING NOT REQUIRED FOR THIS PROCEDURE
4    TIME OUT VERIFIED:  YES
5    MARKED SITE COMMENTS: (WORD PROCESSING)
6    IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
7    TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
8    ASA CLASS:
9    PREOP MOOD:
10   PREOP CONSCIOUS:
11   PREOP SKIN INTEG:
12   TRANS TO OR BY:
13   HAIR REMOVAL BY:
14   HAIR REMOVAL METHOD:
15   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  8:13
ASA Class:  2    2-MILD DISTURB.
Preoperative Mood: RELAXED          R
Preoperative Consciousness: ALERT-ORIENTED          AO
Preoperative Skin Integrity: INTACT          I
Transported to O.R. By: STRETCHER
Preop Surgical Site Hair Removal by: SURNURSE,ONE          OS
```

Example 2: Semicolon

```
** STARTUP **   CASE #24  SURPATIENT,TWO            PAGE 1 OF 3

1    DATE OF OPERATION:     APR 19, 2006 AT 800
2    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE
3    PRIN PRE-OP ICD DIAGNOSIS CODE:
4    OTHER PREOP DIAGNOSIS: (MULTIPLE)
5    OPERATING ROOM:        OR4
6    SURGERY SPECIALTY:     ORTHOPEDICS
7    MAJOR/MINOR:
8    REQ POSTOP CARE:       WARD
9    CASE SCHEDULE TYPE:    ELECTIVE
10   REQ ANESTHESIA TECHNIQUE: GENERAL
11   PATIENT EDUCATION/ASSESSMENT: YES
12   CANCEL DATE:
13   CANCEL REASON:
14   CANCELLATION AVOIDABLE:
15   DELAY CAUSE:          (MULTIPLE)

Enter Screen Server Function:  5;7;
Operating Room:  OR4// OR2
Major or Minor: MAJOR
```

Working with Multiples

The notation MULTIPLE indicates a data element that can have more than one answer. Some multiple fields have several layers of screens from which to respond. Navigating through the layers may seem tedious at first, but the user will soon develop speed. Remember, the user can press the Enter key at the prompt to go back to the main menu screen, or enter an up-arrow (^) to go back to the previous screen.

In the following examples, there are other screens after the initial (also called top-level) screen. With the multiple screens, a new menu list is built with each entry.

Example: Multiples

```
  ** OPERATION **   CASE #14  SURPATIENT,THREE            PAGE 1 OF 3

1    TIME PAT IN HOLD AREA: AUG 15, 2001 AT 740
2    TIME PAT IN OR:        AUG 15, 2001 AT 800
3    MARKED SITE CONFIRMED: YES
4    PREOPERATIVE IMAGING CONFIRMED: IMAGING NOT REQUIRED FOR THIS PROCEDURE
5    TIME OUT VERIFIED:    YES
6    MARKED SITE COMMENTS: (WORD PROCESSING)
7    IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
8    TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
9    ANES CARE TIME BLOCK:    (MULTIPLE)(DATA)
10   TIME OPERATION BEGAN: AUG 15, 2001 AT 900

Enter Screen Server Function:  <Enter>
```

```
  ** OPERATION **   CASE #14  SURPATIENT,THREE            PAGE 2 OF 3

1    SPECIMENS:            (WORD PROCESSING)
2    CULTURES:             (WORD PROCESSING)
3    THERMAL UNIT:         (MULTIPLE)
4    ELECTROCAUTERY UNIT:
5    ESU COAG RANGE:
6    ESU CUTTING RANGE:
7    TIME TOURNIQUET APPLIED: (MULTIPLE)
8    PROSTHESIS INSTALLED: (MULTIPLE)
9    REPLACEMENT FLUID TYPE: (MULTIPLE)
10   IRRIGATION:           (MULTIPLE)
11   MEDICATIONS:          (MULTIPLE)(DATA)
12   SPONGE COUNT CORRECT (Y/N): YES
13   SHARPS COUNT CORRECT (Y/N): YES
14   INSTRUMENT COUNT CORRECT (Y/N): YES
15   SPONGE, SHARPS, & INST COUNTER:

Enter Screen Server Function:  8
```

```
  ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE

1    ANESTHESIA TECHNIQUE:  GENERAL
2    ANESTHESIA TECHNIQUE:  LOCAL
3    NEW ENTRY
Enter Screen Server Function:  1R
    ANESTHESIA TECHNIQUE: GENERAL// <Enter>
```

The software processes the information and produces an update.

```
  ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE  (0)

1    ANESTHESIA TECHNIQUE:  GENERAL
2    PRINCIPAL TECH:
3    ANESTHESIA AGENTS:     (MULTIPLE)

Enter Screen Server Function:  3
```

```
 ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
0)
           ANESTHESIA AGENTS

1    NEW ENTRY

Enter Screen Server Function:  1
Select ANESTHESIA AGENTS: PROCAINE HYDROCHLORIDE
    ANESTHESIA AGENTS: PROCAINE HYDROCHLORIDE // <Enter>
```

```
  ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE  (0)
           ANESTHESIA AGENTS

1    ANESTHESIA AGENTS:     PROCAINE HYDROCHLORIDE
2    NEW ENTRY

Enter Screen Server Function: <Enter>
```

The software processes the information and produces an update.

```
  ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE  (0)

1    ANESTHESIA TECHNIQUE:  GENERAL
2    PRINCIPAL TECH:
3    ANESTHESIA AGENTS:     (MULTIPLE)(DATA)

Enter Screen Server Function:  <Enter>
```

The updating continues through to the top layer.

```
  ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE

1    ANESTHESIA TECHNIQUE:  INTRAVENOUS
2    ANESTHESIA TECHNIQUE:  LOCAL
3    ANESTHESIA TECHNIQUE:  INTRAVENOUS
4    NEW ENTRY

Enter Screen Server Function:
```

Word Processing

The phrase “Word Processing” in the menu means that the user can enter as much data as needed to complete the entry.

Following is an example of how we entered text on a Screen Server word processing field. Notice that we pressed the Enter key after each line of text as there is no automatic word-wrap:

```
** SHORT SCREEN **   CASE #25  SURPATIENT,FOUR       PAGE 3 OF 4

1    SPONGE, SHARPS, & INST COUNTER:
2    COUNT VERIFIER:
3    SURGERY SPECIALTY:       GENERAL
4    WOUND CLASSIFICATION:
5    ATTEND SURG:
6    ATTENDING CODE:       LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE
7    SPECIMENS:            (WORD PROCESSING)
8    CULTURES:             (WORD PROCESSING)
9    NURSING CARE COMMENTS: (WORD PROCESSING)
10   ASA CLASS:
11   PRINC ANESTHETIST:
12   ANESTHESIA TECHNIQUE: (MULTIPLE)
13   ANES CARE TIME BLOCK:    (MULTIPLE)
14   DELAY CAUSE:             (MULTIPLE)
15   CANCEL DATE:

Enter Screen Server Function:  9
NURSING CARE COMMENTS:
  1>Patient arrived ambulatory from Ambulatory Surgery Unit.  <Enter>
  2>Discharged via wheelchair.  Lidocaine applied topically.       <Enter>
  3> <Enter>
EDIT Option: <Enter>
```

The software processes the information and produces an update.

```
** SHORT SCREEN **   CASE #25  SURPATIENT,FOUR       PAGE 3 OF 4

1    SPONGE, SHARPS, & INST COUNTER:
2    COUNT VERIFIER:
3    SURGERY SPECIALTY:       GENERAL
4    WOUND CLASSIFICATION:
5    ATTEND SURG:
6    ATTENDING CODE:       LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE
7    SPECIMENS:            (WORD PROCESSING)
8    CULTURES:             (WORD PROCESSING)
9    NURSING CARE COMMENTS: (WORD PROCESSING)(DATA)
10   ASA CLASS:
11   PRINC ANESTHETIST:
12   ANESTHESIA TECHNIQUE: (MULTIPLE)
13   ANES CARE TIME BLOCK:    (MULTIPLE)
14   DELAY CAUSE:             (MULTIPLE)
15   CANCEL DATE:

Enter Screen Server Function:
```

Example: Operation Startup

```
Select Operation Menu Option: OS  Operation Startup
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE            PAGE 1 OF 3

1    DATE OF OPERATION:     DEC 06, 2004 AT 08:00
2    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
3    PRIN PRE-OP ICD DIAGNOSIS CODE:
4    OTHER PREOP DIAGNOSIS: (MULTIPLE)
5    OPERATING ROOM:        OR2
6    SURGERY SPECIALTY:     ORTHOPEDICS
7    MAJOR/MINOR:
8    REQ POSTOP CARE:       WARD
9    CASE SCHEDULE TYPE:    ELECTIVE
10   REQ ANESTHESIA TECHNIQUE: GENERAL
11   PATIENT EDUCATION/ASSESSMENT:
12   CANCEL DATE:
13   CANCEL REASON:
14   CANCELLATION AVOIDABLE:
15   DELAY CAUSE:           (MULTIPLE)

Enter Screen Server Function: 7;11
Major or Minor: J  MAJOR
Preoperative Patient Education: Y  YES
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE            PAGE 1 OF 3

1    DATE OF OPERATION:     DEC 06, 2004 AT 08:00
2    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
3    PRIN PRE-OP ICD DIAGNOSIS CODE:
4    OTHER PREOP DIAGNOSIS: (MULTIPLE)
5    OPERATING ROOM:        OR2
6    SURGERY SPECIALTY:     ORTHOPEDICS
7    MAJOR/MINOR:           MAJOR
8    REQ POSTOP CARE:       WARD
9    CASE SCHEDULE TYPE:    ELECTIVE
10   REQ ANESTHESIA TECHNIQUE: GENERAL
11   PATIENT EDUCATION/ASSESSMENT:  YES
12   CANCEL DATE:
13   CANCEL REASON:
14   CANCELLATION AVOIDABLE:
15   DELAY CAUSE:           (MULTIPLE)

Enter Screen Server Function: <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE            PAGE 2 OF 3

1    VALID ID/CONSENT CONFIRMED BY:
2    MARKED SITE CONFIRMED:
3    PREOPERATIVE IMAGING CONFIRMED:
4    TIME OUT VERIFIED:
5    MARKED SITE COMMENTS: (WORD PROCESSING)
6    IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
7    TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
8    ASA CLASS:
9    PREOP MOOD:
10   PREOP CONSCIOUS:
11   PREOP SKIN INTEG:
12   TRANS TO OR BY:
13   HAIR REMOVAL BY:
14   HAIR REMOVAL METHOD:
15   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  A
```

```
Person Confirming ID Band and Valid Consent: SURNURSE,ONE
Mark on Surgical Site Confirmed: YES
Preoperative Imaging Confirmed: YES
Time Out Verification Completed (Y/N): YES//  <Enter>
Mark on Surgical Site Comments:
  No existing text
  Edit? NO//  <Enter>
Imaging Confirmed Comments:
  No existing text
  Edit? NO//  <Enter>
Time Out Verification Comments:
  No existing text
  Edit? NO//  <Enter>
ASA Class: 2  2-MILD DISTURB.
Preoperative Mood: ?
     Enter the code corresponding to the preoperative assessment of the
     patient's emotional status upon arrival to the operating room.
     Screen prevents selection of inactive entries.
ANSWER WITH PATIENT MOOD  NAME, OR CODE
CHOOSE FROM:
       AGITATED       AG
       ANGRY          ANG
       ANXIOUS        ANX
       APATHETIC      AP
       DEPRESSED      D
       RELAXED        R
       TESTY AND IRRATE, SLEEPY        BUF

Preoperative Mood: ANXIOUS          ANX
Preoperative Consciousness: AO  ALERT-ORIENTED          AO
Preoperative Skin Integrity: INTACT          I
Transported to O.R. By: PACU  BED
Preop Surgical Site Hair Removal by: SURNURSE,TWO
Surgical Site Hair Removal Method: N  NO HAIR REMOVED
Hair Removal Comments:
  No existing text
  Edit? NO//  <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 2 OF 3

1    VALID ID/CONSENT CONFIRMED BY: SURNURSE,ONE
2    MARKED SITE CONFIRMED:    YES
3    PREOPERATIVE IMAGING CONFIRMED: YES
4    TIME OUT VERIFIED:        YES
5    MARKED SITE COMMENTS: (WORD PROCESSING)
6    IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
7    TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
8    ASA CLASS:               2-MILD DISTURB.
9    PREOP MOOD:              ANXIOUS
10   PREOP CONSCIOUS:         ALERT-ORIENTED
11   PREOP SKIN INTEG:        INTACT
12   TRANS TO OR BY:          PACU BED
13   HAIR REMOVAL BY:         SURNURSE,TWO
14   HAIR REMOVAL METHOD:     NO HAIR REMOVED
15   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

```
  ** STARTUP **    CASE #159  SURPATIENT,THREE             PAGE 3 OF 3

1    SKIN PREPPED BY (1):
2    SKIN PREPPED BY (2):
3    SKIN PREP AGENTS:
4    SECOND SKIN PREP AGENT:
5    SURGERY POSITION:        (MULTIPLE)(DATA)
6    RESTR & POSITION AIDS:   (MULTIPLE)(DATA)
7    ELECTROGROUND POSITION:
8    ELECTROGROUND POSITION (2):

Enter Screen Server Function:  A
```

```
Skin Prepped By: <Enter>
Skin Prepped By (2): <Enter>
Skin Preparation Agent: HIBICLENS          HI
Second Skin Preparation Agent: <Enter>
Electroground Placement:  RAT  RIGHT ANT THIGH
Electroground Position (2):<Enter>
```

```
 ** STARTUP **   CASE #159  SURPATIENT,THREE            PAGE 1
        SURGERY POSITION

1    SURGERY POSITION:      SUPINE
2    NEW ENTRY

Enter Screen Server Function:  2
Select SURGERY POSITION: SEMISUPINE
   ARE YOU ADDING 'SEMISUPINE' AS A NEW SURGERY POSITION (THE 2ND FOR THIS SURGERY)? Y  (YES)
    SURGERY POSITION: SEMISUPINE// <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1
        SURGERY POSITION  (SEMISUPINE)

1    SURGERY POSITION:      SEMISUPINE
2    TIME PLACED:

Enter Screen Server Function:  <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1 OF 1
        SURGERY POSITION

1    SURGERY POSITION:      SUPINE
2    SURGERY POSITION:      SEMISUPINE
3    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1 OF 1
        RESTR & POSITION AIDS

1    RESTR & POSITION AIDS: SAFETY STRAP
2    NEW ENTRY

Enter Screen Server Function:  2
Select RESTR & POSITION AIDS: FOAM PADS
    RESTR & POSITION AIDS: FOAM PADS// <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1 OF 1
        RESTR & POSITION AIDS  (FOAM PADS)

1    RESTR & POSITION AIDS: FOAM PADS
2    APPLIED BY:

Enter Screen Server Function:  2
Applied By: SURNURSE,TWO
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1 OF 1
        RESTR & POSITION AIDS  (FOAM PADS)

1    RESTR & POSITION AIDS: FOAM PADS
2    APPLIED BY:            SURNURSE,TWO

Enter Screen Server Function:  <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1 OF 1
        RESTR & POSITION AIDS

1    RESTR & POSITION AIDS: SAFETY STRAP
2    RESTR & POSITION AIDS: FOAM PADS
3    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
  ** STARTUP **    CASE #159  SURPATIENT,THREE              PAGE 3 OF 3

1    SKIN PREPPED BY (1):
2    SKIN PREPPED BY (2):
3    SKIN PREP AGENTS:        HIBICLENS
4    SECOND SKIN PREP AGENT:
5    SURGERY POSITION:        (MULTIPLE)(DATA)
6    RESTR & POSITION AIDS:   (MULTIPLE)(DATA)
7    ELECTROGROUND POSITION:  RIGHT ANT THIGH
8    ELECTROGROUND POSITION (2):

Enter Screen Server Function:
```

Enter PAC(U) Information
[SROMEN-PACU]

Personnel in the Post Anesthesia Care Unit (PACU) use the *Enter PAC(U) Information* option to enter the admission and discharge times and scores.

Example: Entering PAC(U) Information

```
Select Operation Menu Option: PAC  Enter PAC(U) Information

 ** PACU **   CASE #145  SURPATIENT,NINE               PAGE 1 OF 1

1    ADMIT PAC(U) TIME:
2    PAC(U) ADMIT SCORE:
3    PAC(U) DISCH TIME:
4    PAC(U) DISCH SCORE:

Enter Screen Server Function: 1:4
PAC(U) Admission Time: 13:00  (APR 26, 1999@13:00)
PAC(U) Admission Score: 10
PAC(U) Discharge Date/Time: 14:00  (APR 26, 1999@14:00)
PAC(U) Discharge Score: 10

 ** PACU **   CASE #145  SURPATIENT,NINE               PAGE 1 OF 1

1    ADMIT PAC(U) TIME:     APR 26, 1999 AT 13:00
2    PAC(U) ADMIT SCORE:    10
3    PAC(U) DISCH TIME:     APR 26, 1999 AT 14:00
4    PAC(U) DISCH SCORE:    10

Enter Screen Server Function:
```

Operation (Short Screen)
[SROMEN-OUT]

The *Operation (Short Screen)* option provides a three-page screen of information concerning a surgical procedure performed on a patient. The *Operation (Short Screen)* option allows the nurse or surgeon to easily enter data relating to the operation during, and shortly after, the actual procedure. This time-saving option can replace the *Operation Startup* option, the *Operation* option, and the *Post Operation* option for minor surgeries.

When only one anesthesia technique is entered, the software will assume that it is the principal anesthesia technique for the case. Some data fields may be automatically pre-populated if the case was booked in advance.

Example: Operation Short Screen

```
Select Operation Menu Option: OSS  Operation (Short Screen)

  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 1 OF 4

1    DATE OF OPERATION:     MAR 09, 2005
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,FOUR
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE:   REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE: 17000
9    OTHER PROCEDURES:      (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:
14   MARKED SITE CONFIRMED:
15   PREOPERATIVE IMAGING CONFIRMED:

Enter Screen Server Function: 13:15
Time Patient In the O.R.: 13:00  (MAR 09, 2005@13:00)
Mark on Surgical Site Confirmed: Y  YES
Preoperative Imaging Confirmed: ?

Enter YES if the imaging data was confirmed, "I" if there was no imaging
     required, or "NO" if the image was not viewed.
     Choose from:
       Y        YES
       I        IMAGING NOT REQUIRED FOR THIS PROCEDURE
       N        NO - IMAGING REQUIRED BUT NOT VIEWED (see CORRECT SURGERY COMMEN
TS)
Preoperative Imaging Confirmed: I IMAGING NOT REQUIRED FOR THIS PROCEDURE
```

```
  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 1 OF 4

1    DATE OF OPERATION:     MAR 09, 2005
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,FOUR
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE:   REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE: 17000
9    OTHER PROCEDURES:      (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:        MAR 09, 2005 AT 13:00
14   MARKED SITE CONFIRMED: YES
15   PREOPERATIVE IMAGING CONFIRMED: IMAGING NOT REQUIRED FOR THIS PROCEDURE

Enter Screen Server Function:  <Enter>
```

```
  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 2 OF 4

1    TIME OUT VERIFIED:
2    MARKED SITE COMMENTS: (WORD PROCESSING)
3    IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
4    TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
5    TIME OPERATION BEGAN:
6    TIME OPERATION ENDS:
7    TIME PAT OUT OR:
8    IV STARTED BY:
9    OR CIRC SUPPORT:       (MULTIPLE)
10   OR SCRUB SUPPORT:      (MULTIPLE)
11   OPERATING ROOM:        OR3
12   FIRST ASST:            SURSURGEON,THIRTY
13   SPONGE COUNT CORRECT (Y/N):
14   SHARPS COUNT CORRECT (Y/N):
15   INSTRUMENT COUNT CORRECT (Y/N):

Enter Screen Server Function:  1;5:7

Time Out Verification Completed (Y/N): Y  YES
Time the Operation Began: 13:10  (MAR 09, 2005@13:10)
Time the Operation Ends: 13:36  (MAR 09, 2005@13:36)
Time Patient Out of the O.R.: 13:40  (MAR 09, 2005@13:40)
```

```
  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 2 OF 4

1    TIME OUT VERIFIED:     YES
2    MARKED SITE COMMENTS: (WORD PROCESSING)
3    IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
4    TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
5    TIME OPERATION BEGAN:  MAR 09, 2005 at 13:10
6    TIME OPERATION ENDS:   MAR 09, 2005 AT 13:36
7    TIME PAT OUT OR:       MAR 09, 2005 AT 13:40
8    IV STARTED BY:
9    OR CIRC SUPPORT:       (MULTIPLE)
10   OR SCRUB SUPPORT:      (MULTIPLE)
11   OPERATING ROOM:        OR3
12   FIRST ASST:            SURSURGEON,THIRTY
13   SPONGE COUNT CORRECT (Y/N):
14   SHARPS COUNT CORRECT (Y/N):
15   INSTRUMENT COUNT CORRECT (Y/N):

Enter Screen Server Function:  <Enter>
```

```
  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 3 OF 4

1    SPONGE, SHARPS, & INST COUNTER:
2    COUNT VERIFIER:
3    SURGERY SPECIALTY:     PLASTIC SURGERY (INCLUDES HEAD AND NECK)
4    WOUND CLASSIFICATION:
5    ATTEND SURG:           SURSURGEON,TWO
6    ATTENDING CODE:
7    SPECIMENS:             (WORD PROCESSING)
8    CULTURES:              (WORD PROCESSING)
9    NURSING CARE COMMENTS: (WORD PROCESSING)
10   ASA CLASS:
11   PRINC ANESTHETIST:     SURANESTHETIST,FOUR
12   ANESTHESIA TECHNIQUE:  (MULTIPLE)
13   ANES CARE TIME BLOCK:  (MULTIPLE)
14   DELAY CAUSE:           (MULTIPLE)
15   CANCEL DATE:

Enter Screen Server Function:  6;9
Attending Code: A   LEVEL A: ATTENDING DOING THE OPERATION
Nursing Care Comments:
  1>PATIENT ARRIVED AMBULATORY FROM AMBULATORY
  2>SURGERY UNIT. DISCHARGED VIA WHEELCHAIR, AWAKE,
  3>ALERT, ORIENTED.
  4><Enter>
EDIT Option:  <Enter>
```

```
  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 3 OF 4

1    SPONGE, SHARPS, & INST COUNTER:
2    COUNT VERIFIER:
3    SURGERY SPECIALTY:     PLASTIC SURGERY (INCLUDES HEAD AND NECK)
4    WOUND CLASSIFICATION:
5    ATTEND SURG:           SURSURGEON,TWO
6    ATTENDING CODE:         LEVEL A: ATTENDING DOING THE OPERATION
7    SPECIMENS:             (WORD PROCESSING)
8    CULTURES:              (WORD PROCESSING)
9    NURSING CARE COMMENTS: (WORD PROCESSING) (DATA)
10   ASA CLASS:
11   PRINC ANESTHETIST:     SURANESTHETIST,FOUR
12   ANESTHESIA TECHNIQUE:  (MULTIPLE)
13   ANES CARE TIME BLOCK:  (MULTIPLE)
14   DELAY CAUSE:           (MULTIPLE)
15   CANCEL DATE:

Enter Screen Server Function:  <Enter>
```

```
  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 4 OF 4

1    CANCEL REASON:

Enter Screen Server Function:
```

Nurse Intraoperative Report - Before Electronic Signature

Upon selecting the *Nurse Intraoperative Report* option, if the Nurse Intraoperative Report is not signed, the report will begin displaying on the screen. The Nurse Intraoperative Report displays key fields on the first page. Several of these fields are required before the software will allow the user to electronically sign the report. If any required fields are left blank, a warning will appear prompting the user to provide the missing information.

The Nurse Intraoperative Report must have the TIME PAT IN OR field and the TIME PAT OUT OR field entered prior to electronic signature. The MARKED SITE CONFIRMED, TIME OUT VERIFIED, PREOPERATIVE IMAGING CONFIRMED, and HAIR REMOVAL BY fields are also required before this report can be electronically signed. Additionally, if the COUNT VERIFIER field has been entered, the SPONGE COUNT CORRECT (Y/N) field, SHARPS COUNT CORRECT (Y/N) field, INSTRUMENT COUNT CORRECT (Y/N) field, and the SPONGE, SHARPS, & INST COUNTER field will also be required before the Nurse Intraoperative Report can be electronically signed.

Entering the TIME PAT OUT OR field triggers an alert that is sent to the nurse responsible for signing the report. By acting on the alert, the nurse accesses the *Nurse Intraoperative Report* option to electronically sign the report.

At the bottom of the first screen is the prompt, "Press <return> to continue, 'A' to access Nurse Intraoperative Report functions or '^' to exit:". The *Nurse Intraoperative Report* functions, accessed by entering **A** at the prompt, allow the user to edit the report, to view or print the report, or to electronically sign the report.

Example: First page of the Nurse Intraoperative Report

```
Select Operation Menu Option: NR  Nurse Intraoperative Report

                          SURPATIENT,TEN (000-12-3456)
   MEDICAL RECORD       NURSE INTRAOPERATIVE REPORT - CASE #267226       PAGE 1

Operating Room:  BO OR1                 Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004  07:30    Patient in OR:  JUL 12, 2004  08:00
Operation Begin: JUL 12, 2004  08:58    Operation End:  JUL 12, 2004  12:10
Surgeon in OR:   JUL 12, 2004  07:55    Patient Out OR: JUL 12, 2004  12:45

Major Operations Performed:
Primary: MVR

Wound Classification: CLEAN
Operation Disposition: SICU
Discharged Via: ICU BED

Surgeon: SURSURGEON,THREE               First Assist: SURSURGEON,FOUR
Attend Surg: SURSURGEON,THREE           Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN       Assistant Anesth: N/A

 Press <return> to continue, 'A' to access Nurse Intraoperative Report
 functions, or '^' to exit: A
```

After the user enters an **A** at the prompt, the *Nurse Intraoperative Report* functions are displayed. The following examples demonstrate how these three functions are accessed and how they operate.
If the user enters a **1**, the Nurse Intraoperative Report data can be edited.

Example: Editing the Nurse Intraoperative Report

```
SURPATIENT,TEN (000-12-3456)   Case #267226 - JUL 12, 2004

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 1
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

1    SPONGE COUNT CORRECT (Y/N):
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,FOUR
5    COUNT VERIFIER:     SURNURSE,FIVE
6    TIME PAT IN HOLD AREA: JUL 12, 2004 AT 07:30
7    TIME PAT IN OR:     JUL 12, 2004 AT 08:00
8    MARKED SITE CONFIRMED: YES
9    PREOPERATIVE IMAGING CONFIRMED: YES
10   TIME OUT VERIFIED: YES
11   MARKED SITE COMMENTS: (WORD PROCESSING)
12   IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
13   TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
14   TIME OPERATION BEGAN: JUL 12, 2004 AT 08:58
15   TIME OPERATION ENDS:  JUL 12, 2004 AT 12:10

Enter Screen Server Function: <Enter>
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 2 OF 6

1    SURG PRESENT TIME:  JUL 12, 2004 AT 07:55
2    TIME PAT OUT OR:    JUL 12, 2004 AT 12:45
3    PRINCIPAL PROCEDURE:  MVR
4    OTHER PROCEDURES:     (MULTIPLE)
5    WOUND CLASSIFICATION: CLEAN
6    OP DISPOSITION:       SICU
7    MAJOR/MINOR:
8    OPERATING ROOM:       BO OR1
9    CASE SCHEDULE TYPE:   ELECTIVE
10   SURGEON:              SURSURGEON,THREE
11   ATTEND SURG:          SURSURGEON,THREE
12   FIRST ASST:          SURSURGEON,FOUR
13   SECOND ASST:
14   PRINC ANESTHETIST:  SURANESTHETIST,SEVEN
15   ASST ANESTHETIST:

Enter Screen Server Function:  5
Wound Classification: CLEAN// CONTAMINATED  CONTAMINATED
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 2 OF 6

1    SURG PRESENT TIME:  JUL 12, 2004 AT 07:55
2    TIME PAT OUT OR:    JUL 12, 2004 AT 12:45
3    PRINCIPAL PROCEDURE:  MVR
4    OTHER PROCEDURES:     (MULTIPLE)
5    WOUND CLASSIFICATION: CONTAMINATED
6    OP DISPOSITION:       SICU
7    MAJOR/MINOR:
8    OPERATING ROOM:        BO OR1
9    CASE SCHEDULE TYPE:   ELECTIVE
10   SURGEON:             SURSURGEON,THREE
11   ATTEND SURG:         SURSURGEON,THREE
12   FIRST ASST:         SURSURGEON,FOUR
13   SECOND ASST:
14   PRINC ANESTHETIST:  SURANESTHETIST,SEVEN
15   ASST ANESTHETIST:

Enter Screen Server Function: ^
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 3 OF 6

1    OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
2    OR SCRUB SUPPORT:        (MULTIPLE)
3    OR CIRC SUPPORT:         (MULTIPLE)
4    OTHER PERSONS IN OR:     (MULTIPLE)
5    PREOP MOOD:              ANXIOUS
6    PREOP CONSCIOUS:         ALERT-ORIENTED
7    PREOP SKIN INTEG:        INTACT
8    PREOP CONVERSE:          NOT ANSWER QUESTIONS
9    VALID ID/CONSENT CONFIRMED BY: SURSURGEON,FOUR
10   HAIR REMOVAL BY:         SURNURSE,FIVE
11   HAIR REMOVAL METHOD:     OTHER
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)(DATA)
13   SKIN PREPPED BY (1):     SURNURSE,FIVE
14   SKIN PREPPED BY (2):
15   SKIN PREP AGENTS:        BETADINE

Enter Screen Server Function:  ^
```

If SHAVING or OTHER is entered as the Hair Removal Method, then Hair Removal Comments must be entered before the report can be electronically signed.

At the *Nurse Intraoperative Report* functions, the report can be printed if the user enters a **2**.

Example: Printing the Nurse Intraoperative Report

```
SURPATIENT,TEN (000-12-3456)   Case #267226 - JUL 12, 2004

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// <Enter>
```

----------*printout follows*----------

```
------------------------------------------------------------------------------
SURPATIENT,TEN  000-12-3456                        NURSE INTRAOPERATIVE REPORT
------------------------------------------------------------------------------
NOTE DATED: 07/12/2004 08:00  NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room:  BO OR1                Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004  07:30   Patient in OR:  JUL 12, 2004  08:00
Operation Begin: JUL 12, 2004  08:58   Operation End:  JUL 12, 2004  12:10
Surgeon in OR:   JUL 12, 2004  07:55   Patient Out OR: JUL 12, 2004  12:45

Major Operations Performed:
Primary: MVR

Wound Classification: CONTAMINATED
Operation Disposition: SICU
Discharged Via: ICU BED

Surgeon: SURSURGEON,THREE              First Assist: SURSURGEON,FOUR
Attend Surg: SURSURGEON,THREE          Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN            Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:
  Scrubbed                             Circulating
 SURNURSE,ONE (FULLY TRAINED)          SURNURSE,FIVE (FULLY TRAINED)
                                       SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood:       ANXIOUS              Preop Consc:    ALERT-ORIENTED
Preop Skin Integ: INTACT               Preop Converse: N/A

Valid Consent/ID Band Confirmed By: SURSURGEON,FOUR
Mark on Surgical Site Confirmed: YES
  Marked Site Comments: NO COMMENTS ENTERED

Preoperative Imaging Confirmed: YES
  Imaging Confirmed Comments: NO COMMENTS ENTERED

Time Out Verification Completed: YES
  Time Out Verified Comments: NO COMMENTS ENTERED

Skin Prep By: SURNURSE,FOUR             Skin Prep Agent: BETADINE SCRUB
Skin Prep By (2): SURNURSE,FIVE         2nd Skin Prep Agent: POVIDONE IODINE

Preop Surgical Site Hair Removal by: SURNURSE,FIVE
Surgical Site Hair Removal Method: OTHER
  Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):
  SUPINE                               Placed: N/A

Restraints and Position Aids:
  SAFETY STRAP                     Applied By: N/A
  ARMBOARD                         Applied By: N/A
  FOAM PADS                        Applied By: N/A
  KODEL PAD                        Applied By: N/A
  STIRRUPS                         Applied By: N/A

Electrocautery Unit:       8845,5512
ESU Coagulation Range:     50-35
ESU Cutting Range:         35-35
Electroground Position(s): RIGHT BUTTOCK
                           LEFT BUTTOCK
```

```
Material Sent to Laboratory for Analysis:
Specimens:
 1. MITRAL VALVE
Cultures:  N/A

Anesthesia Technique(s):
 GENERAL  (PRINCIPAL)


Tubes and Drains:
  #16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
  Item: MITRAL VALVE
    Vendor: BAXTER EDWARDS
    Model: 6900
    Lot/Serial Number: GY0755                       Sterile Resp: MANUFACTURER
    Size: 29MM                                      Quantity: 1

Medications: N/A

Irrigation Solution(s):
  HEPARINIZED SALINE
  NORMAL SALINE
  COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count:
Sharps Count:       YES
Instrument Count:   NOT APPLICABLE
Counter:            SURNURSE,FOUR
Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing:  NONE

Blood Loss: 800 ml                     Urine Output: 750 ml

Postoperative Mood:           RELAXED
Postoperative Consciousness:  ANESTHETIZED
Postoperative Skin Integrity: SUTURED INCISION
Postoperative Skin Color:     N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:
  PATIENT STATES HE IS ALLERGIC TO PCN. ALL WRVAMC INTRAOPERATIVE NURSING
  STANDARDS WERE MONITORED THROUGHOUT THE PROCEDURE. VANCYMYCIN PASTE WAS
  APPLIED TO STERNUM.
```

To electronically sign the report, the user enters a **3** at the *Nurse Intraoperative Report* functions prompt.

Example: Signing the Nurse Intraoperative Report

```
SURPATIENT,TEN (000-12-3456)   Case #267226 - JUL 12, 2004

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 3
```

The Nurse Intraoperative Report may only be signed by a circulating nurse on the case. At the time of electronic signature, the software checks for data in key fields. The nurse will not be able to sign the report if the TIME PATIENT IN OR field and the TIME PATIENT OUT OF OR fields are not entered. The MARKED SITE CONFIRMED, TIME OUT VERIFIED, PREOPERATIVE IMAGING CONFIRMED, and HAIR REMOVAL METHOD fields are also required before this report can be electronically signed. Also, if the COUNT VERIFIER field is entered, the other counts related fields must be populated. These count fields include the following:

SPONGE COUNT CORRECT
SHARPS COUNT CORRECT (Y/N)
INSTRUMENT COUNT CORRECT (Y/N)
SPONGE, SHARPS, & INST COUNTER

If any of the key fields are missing, the software will require them to be entered prior to signature. In the following example, the final sponge count must be entered before the nurse is allowed to electronically sign the report.

Example: Missing Field Warning

```
The following information is required before this report may be signed:

     Final Sponge Count Correct (Y/N)

Do you want to enter this information? YES// YES
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

1    SPONGE COUNT CORRECT (Y/N):
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,FOUR
5    COUNT VERIFIER:     SURNURSE,FIVE
6    TIME PAT IN HOLD AREA: JUL 12, 2004 AT 07:30
7    TIME PAT IN OR:     JUL 12, 2004 AT 08:00
8    MARKED SITE CONFIRMED: YES
9    PREOPERATIVE IMAGING CONFIRMED: YES
10   TIME OUT VERIFIED: YES
11   MARKED SITE COMMENTS: (WORD PROCESSING)
12   IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
13   TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
14   TIME OPERATION BEGAN: JUL 12, 2004 AT 08:58
15   TIME OPERATION ENDS:  JUL 12, 2004 AT 12:10

Enter Screen Server Function:  1
```

```
Final Sponge Count Correct (Y/N): Y  YES
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,FOUR
5    COUNT VERIFIER:     SURNURSE,FIVE
6    TIME PAT IN HOLD AREA: JUL 12, 2004 AT 07:30
7    TIME PAT IN OR:     JUL 12, 2004 AT 08:00
8    MARKED SITE CONFIRMED: YES
9    PREOPERATIVE IMAGING CONFIRMED: YES
10   TIME OUT VERIFIED: YES
11   MARKED SITE COMMENTS: (WORD PROCESSING)
12   IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
13   TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
14   TIME OPERATION BEGAN: JUL 12, 2004 AT 08:58
15   TIME OPERATION ENDS:  JUL 12, 2004 AT 12:10

Enter Screen Server Function: ^
```

If any of the correct surgery fields – MARKED SITE CONFIRMED, PREOPERATIVE IMAGING CONFIRMED, and TIME OUT VERIFIED – are answered with "NO", then the user is prompted to enter information in the respective comments field. Entry in the comments field is required, in such cases where "NO" has been entered, before the user can electronically sign the Nurse Intraoperative Report.

```
SURPATIENT,TEN (000-12-3456)   Case #267226 - JUL 12, 2004

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning
  3. Sign the report electronically

Select number: 2// 3  Sign the report electronically

Enter your Current Signature Code: XXX   SIGNATURE VERIFIED

Press RETURN to continue... <Enter>
```

When typing the electronic signature code, no characters will display on screen.

```
 SURPATIENT,TEN (000-12-3456)   Case #267226 - JUL 12, 2004

 * * The Nurse Intraoperative Report has been electronically signed. * *

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning

Select number: 2// ^
```

Nurse Intraoperative Report - After Electronic Signature

After the report has been signed, any changes to the report will require a signed addendum.

Example: Editing the Signed Nurse Intraoperative Report

```
 SURPATIENT,TEN (000-12-3456)   Case #267226 - FEB 12, 2004

 * * The Nurse Intraoperative Report has been electronically signed. * *

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning

Select number: 2// 1  Edit report information
```

If the Anesthesia Report and/or the Nurse Intraoperative Report is already signed, the following warning will be displayed. If any data on either signed report is edited, an addendum to the Anesthesia Report and/or to the Nurse Intraoperative Report will be required.

```
 SURPATIENT,TEN (000-12-3456)   Case #267226 - FEB 12,2004


                              >>>  WARNING  <<<

   Electronically signed reports are associated with this case. Editing
   of data that appear on electronically signed reports will require the
   creation of addenda to the signed reports.



Enter RETURN to continue or '^' to exit: <Enter>
```

First, the user makes the edits to the desired field.

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,FOUR
5    COUNT VERIFIER:     SURNURSE,FIVE
6    TIME PAT IN HOLD AREA: FEB 12, 2004 AT 07:30
7    TIME PAT IN OR:     FEB 12, 2004 AT 08:00
8    MARKED SITE CONFIRMED: YES
9    PREOPERATIVE IMAGING CONFIRMED: YES
10   TIME OUT VERIFIED: YES
11   MARKED SITE COMMENTS: (WORD PROCESSING)
12   IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
13   TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
14   TIME OPERATION BEGAN: JUL 12, 2004 AT 08:58
15   TIME OPERATION ENDS:  JUL 12, 2004 AT 12:10

Enter Screen Server Function:  15
Time the Operation Ends: FEB 12,2004@12:10// 1230  (FEB 12, 2004@12:30)
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,FOUR
5    COUNT VERIFIER:     SURNURSE,FIVE
6    TIME PAT IN HOLD AREA: JUL 12, 2004 AT 07:30
7    TIME PAT IN OR:     JUL 12, 2004 AT 08:00
8    MARKED SITE CONFIRMED: YES
9    PREOPERATIVE IMAGING CONFIRMED: YES
10   TIME OUT VERIFIED: YES
11   MARKED SITE COMMENTS: (WORD PROCESSING)
12   IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
13   TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
14   TIME OPERATION BEGAN: JUL 12, 2004 AT 08:58
15   TIME OPERATION ENDS:  JUL 12, 2004 AT 12:30

Enter Screen Server Function:  <Enter>
```

An addendum is required before the edit can be made to the signed report.

```
SURPATIENT,TEN (000-12-3456)   Case #267226 - JUL 12, 2004

An addendum to each of the following electronically signed document(s) is
required:

          Nurse Intraoperative Report - Case #267226

If you choose not to create an addendum, the original data will be restored
to the modified fields appearing on the signed reports.


Create addendum? YES//  <Enter>
```

```
Addendum for Case #267226 - JUL 12,2004
Patient: SURPATIENT,TEN (000-12-3456)
------------------------------------------------------------------------------

The Time the Operation Ends field was changed
  from JUL 12, 2004@12:10
    to JUL 12, 2004@12:30

Enter RETURN to continue or '^' to exit: <Enter>
```

Before the addendum is signed, comments may be added.

Example: Signing the Addendum

```
Comment: OPERATION END TIME WAS CORRECTED.

Addendum for Case #267226 - JUL 12,2004
Patient: SURPATIENT,TEN (000-12-3456)
------------------------------------------------------------------------------

The Time the Operation Ends field was changed
  from JUL 12, 2004@12:10
    to JUL 12, 2004@12:30

Addendum Comment: OPERATION END TIME WAS CORRECTED.

Enter RETURN to continue or '^' to exit:

Enter your Current Signature Code: XXX   SIGNATURE VERIFIED..

Press RETURN to continue... <Enter>
```

When typing the electronic signature code, no characters will display on screen.

Example: Printing the Nurse Intraoperative Report

```
SURPATIENT,TEN (000-12-3456)   Case #267226 - JUL 12, 2004

 * * The Nurse Intraoperative Report has been electronically signed. * *

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning

Select number: 2// 2  Print/View report from beginning

Do you want WORK copies or CHART copies? WORK// <Enter>

DEVICE: HOME//  [Select Print Device]
```

----------*printout follows*----------

```
------------------------------------------------------------------------------
SURPATIENT,TEN  000-12-3456                        NURSE INTRAOPERATIVE REPORT
------------------------------------------------------------------------------
NOTE DATED: 07/12/2004 08:00  NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room:  BO OR1                 Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004  07:30    Patient in OR:  JUL 12, 2004  08:00
Operation Begin: JUL 12, 2004  08:58    Operation End:  JUL 12, 2004  12:30
Surgeon in OR:   JUL 12, 2004  07:55    Patient Out OR: JUL 12, 2004  12:45

Major Operations Performed:
Primary: MVR

Wound Classification: CONTAMINATED
Operation Disposition: SICU
Discharged Via: ICU BED

Surgeon: SURSURGEON,THREE               First Assist: SURSURGEON,FOUR
Attend Surg: SURSURGEON,THREE           Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN             Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:
  Scrubbed                              Circulating
 SURNURSE,ONE (FULLY TRAINED)           SURNURSE,FIVE (FULLY TRAINED)
                                        SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood:       ANXIOUS               Preop Consc:    ALERT-ORIENTED
Preop Skin Integ: INTACT                Preop Converse: N/A

Valid Consent/ID Band Confirmed By: SURSURGEON,FOUR
Mark on Surgical Site Confirmed: YES
  Marked Site Comments: NO COMMENTS ENTERED

Preoperative Imaging Confirmed: YES
  Imaging Confirmed Comments: NO COMMENTS ENTERED

Time Out Verification Completed: YES
  Time Out Verified Comments: NO COMMENTS ENTERED

Skin Prep By: SURNURSE,FOUR             Skin Prep Agent: BETADINE SCRUB
Skin Prep By (2): SURNURSE,FIVE         2nd Skin Prep Agent: POVIDONE IODINE

Preop Surgical Site Hair Removal by: SURNURSE,FIVE
Surgical Site Hair Removal Method: OTHER
  Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):
  SUPINE                                Placed: N/A

Restraints and Position Aids:
  SAFETY STRAP                      Applied By: N/A
  ARMBOARD                          Applied By: N/A
  FOAM PADS                         Applied By: N/A
  KODEL PAD                         Applied By: N/A
  STIRRUPS                          Applied By: N/A

Electrocautery Unit:       8845,5512
ESU Coagulation Range:     50-35
ESU Cutting Range:         35-35
Electroground Position(s): RIGHT BUTTOCK
                           LEFT BUTTOCK
```

```
Material Sent to Laboratory for Analysis:
Specimens:
 1. MITRAL VALVE
Cultures:  N/A
Anesthesia Technique(s):
 GENERAL  (PRINCIPAL)


Tubes and Drains:
  #16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
  Item: MITRAL VALVE
    Vendor: BAXTER EDWARDS
    Model: 6900
    Lot/Serial Number: GY0755                       Sterile Resp: MANUFACTURER
    Size: 29MM                                      Quantity: 1

Medications: N/A

Irrigation Solution(s):
  HEPARINIZED SALINE
  NORMAL SALINE
  COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count:       YES
Sharps Count:       YES
Instrument Count:   NOT APPLICABLE
Counter:            SURNURSE,FOUR
Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing:  NONE

Blood Loss: 800 ml                     Urine Output: 750 ml

Postoperative Mood:           RELAXED
Postoperative Consciousness:  ANESTHETIZED
Postoperative Skin Integrity: SUTURED INCISION
Postoperative Skin Color:     N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:
  PATIENT STATES HE IS ALLERGIC TO PCN. ALL WRVAMC INTRAOPERATIVE NURSING
  STANDARDS WERE MONITORED THROUGHOUT THE PROCEDURE. VANCYMYCIN PASTE WAS
  APPLIED TO STERNUM.

                 Signed by: /es/ FIVE SURNURSE
                                 03/04/2004 10:41
04/17/2004 16:42     ADDENDUM

The Time the Operation Ends field was changed
  from JUL 12, 2004@12:10
    to JUL 12, 2004@12:30

Addendum Comment: OPERATION END TIME WAS CORRECTED.

                 Signed by: /es/ FIVE SURNURSE
                                 07/17/2004 16:42
```

Perioperative Occurrences Menu

[SRO COMPLICATIONS MENU]

Surgeons use options within the *Perioperative Occurrences Menu* option to enter or edit occurrences that occur before, during, and/or after a surgical procedure. It is also possible to enter occurrences for a patient who did not have a surgical procedure performed. The user can enter more than one occurrence per patient.

 This option is locked with the SROCOMP key.

Occurrences will be included on the Chief of Surgery's Morbidity & Mortality Reports.

Please review specific institution policy to determine what is considered an occurrence for any category.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
I	*Intraoperative Occurrences (Enter/Edit)*
P	*Postoperative Occurrences (Enter/Edit)*
N	*Non-Operative Occurrences (Enter/Edit)*
U	*Update Status of Returns Within 30 Days*
M	*Morbidity & Mortality Reports*

Key Vocabulary

The following terms are used in this section.

Term	Definition
Intraoperative Occurrence	Occurrence that occurs during the procedure.
Postoperative Occurrence	Occurrence that occurs after the procedure.
Non-Operative Occurrence	Occurrence that develops before a surgical procedure is performed.

Intraoperative Occurrences (Enter/Edit)
[SRO INTRAOP COMP]

The *Intraoperative Occurrences (Enter/Edit)* option is used to add information about an occurrence that occurs during the procedure. The user can also use this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, the user should select an operation. The software will then list any occurrences already entered for that operation. The user may edit a previously entered occurrence or can type the word **NEW** and press the **<Enter>** key to enter a new occurrence.

At the prompt "Enter a New Intraoperative Occurrence:" the user can enter two question marks **(??)** to get a list of categories. Be sure to enter a category for all occurrences to satisfy Surgery Central Office reporting needs.

Example: Entering Intraoperative Occurrences

```
Select Perioperative Occurrences Menu Option: I  Intraoperative Occurrences (Enter/Edit)

Select Patient: SURPATIENT,FIFTY         10-28-45     000459999

 SURPATIENT,FIFTY   000-45-9999

1. 06-30-99   CHOLECYSTECTOMY (COMPLETED)

2. 03-10-99   HEMORRHOIDECTOMY (COMPLETED)


Select Operation: 1
```

```
SURPATIENT,FIFTY (000-45-9999)        Case #213
JUN 30,1999   CHOLECYSTECTOMY (CPT MISSING)
------------------------------------------------------------------------------


There are no Intraoperative Occurrences entered for this case.


Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
NSQIP Definition (2006):
  The absence of cardiac rhythm or presence of chaotic cardiac rhythm
  that results in loss of consciousness requiring the initiation of any
  component of basic and/or advanced cardiac life support. Patients with
  AICDs that fire but the patient does not lose consciousness should be
  excluded.

  CICSP Definition (2004):
  Indicate if there was any cardiac arrest requiring external or open
  cardiopulmonary resuscitation (CPR) occurring in the operating room,
  ICU, ward, or out-of-hospital after the chest had been completely
  closed and within 30 days of surgery.

Press RETURN to continue: <Enter>
```

```
SURPATIENT,FIFTY (000-45-9999)        Case #213
JUN 30,1999   CHOLECYSTECTOMY (CPT MISSING)
------------------------------------------------------------------------------


1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: 4:5
```

```
SURPATIENT,FIFTY  (000-45-9999)
------------------------------------------------------------------------------
Type of Treatment Instituted: CPR
Outcome to Date: ?
     CHOOSE FROM:
       U        UNRESOLVED
       I        IMPROVED
       D        DEATH
       W        WORSE
Outcome to Date: I  IMPROVED
```

```
SURPATIENT,FIFTY (000-45-9999)        Case #213
JUN 30,1999   CHOLECYSTECTOMY (CPT MISSING)
------------------------------------------------------------------------------


1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information:
```

Postoperative Occurrences (Enter/Edit)
[SRO POSTOP COMP]

The *Postoperative Occurrences (Enter/Edit)* option is used to add information about an occurrence that occurs after the procedure. The user can also utilize this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, the user selects an operation. The software will then list any occurrences already entered for that operation. The user can choose to edit a previously entered occurrence or type the word **NEW** and press the **<Enter>** key to enter a new occurrence.

At the prompt "Enter a New Postoperative Complication:" the user can enter two question marks **(??)** to get a list of categories. Be sure to enter a category for all occurrences in order to satisfy Surgery Central Office reporting needs.

Example: Entering a Postoperative Occurrence

```
Select Perioperative Occurrences Menu Option: P  Postoperative Occurrence (Enter/Edit)

Select Patient: SURPATIENT,SEVENTEEN        09-13-28     000455119

 SURPATIENT,SEVENTEEN R.  000-45-5119

1. 04-18-99   CRANIOTOMY (COMPLETED)

2. 03-18-06   REPAIR INCARCERATED INGUINAL HERNIA (COMPLETED)



Select Operation: 2
```

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #202
MAR 18,2006   REPAIR INCARCERATED INGUINAL HERNIA (49505)
------------------------------------------------------------------------------

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: ACUTE RENAL FAILURE
  NSQIP Definition (2006):
  In a patient who did not require dialysis preoperatively, worsening of
  renal dysfunction (increase in serum creatinine to >2.0 and two times
  most recent preoperative creatinine level) and postoperatively
  requiring hemodialysis, peritoneal dialysis, hemofiltration,
  hemodiafiltration or ultrafiltration.

  TIP: If the patient refuses dialysis report as an occurrence because
  he/she did require dialysis.

  CICSP Definition (2004):
  Indicate if the patient developed new renal failure requiring dialysis
  or experienced an exacerbation of preoperative renal failure requiring
  initiation of dialysis (not on dialysis preoperatively) within 30 days
  postoperatively.

Press RETURN to continue: <Enter>
```

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #202
MAR 18,2006   REPAIR INCARCERATED INGUINAL HERNIA (49505)
-------------------------------------------------------------------------------


1. Occurrence:            ACUTE RENAL FAILURE
2. Occurrence Category:   ACUTE RENAL FAILURE
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

-------------------------------------------------------------------------------

Select Occurrence Information: 4:6
```

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #202
MAR 18,2006   REPAIR INCARCERATED INGUINAL HERNIA (49505)
-------------------------------------------------------------------------------


Treatment Instituted: ANTIBIOTICS
Outcome to Date: I  IMPROVED
Date/Time the Occurrence was Noted: 3/20  (MAR 20, 2006)
```

```
SURPATIENT,SEVENTEEN R. (000-45-5119)        Case #202
MAR 18,2006   REPAIR INCARCERATED INGUINAL HERNIA (49505)
-------------------------------------------------------------------------------


1. Occurrence:            ACUTE RENAL FAILURE
2. Occurrence Category:   ACUTE RENAL FAILURE
3. ICD Diagnosis Code:
4. Treatment Instituted:  DIALYSIS
5. Outcome to Date:       IMPROVED
6. Date Noted:            03/20/06
7. Occurrence Comments:

-------------------------------------------------------------------------------

Select Occurrence Information:
```

Non-Operative Occurrence (Enter/Edit) [SROCOMP]

The *Non-Operative Occurrence (Enter/Edit)* option is used to enter or edit occurrences that are not related to surgical procedures. A non-operative occurrence is an occurrence that develops before a surgical procedure is performed.

At the "Occurrence Category:" prompt, the user can enter two question marks **(??)** to get a list of categories. Be sure to enter a category for each occurrence in order to satisfy Surgery Central Office reporting needs.

Example: Entering a Non-Operative Occurrence

```
Select Perioperative Occurrences Menu Option: N  Non-Operative Occurrences (Enter/Edit)

NOTE:  You are about to enter an occurrence for a patient that has not had an
operation during this admission. If this patient has a surgical procedure
during the current admission, use the option to enter or edit intraoperative
and postoperative occurrences.


Select PATIENT NAME: SURPATIENT,SEVENTEEN        09-13-28     000455119


   SURPATIENT,SEVENTEEN

1.           ENTER A NEW NON-OPERATIVE OCCURRENCE



Select Number:  1

Select the Date of Occurrence: T-2  (JUN 30, 2006)
Name of the Surgeon Treating the Complication: SURSURGEON,ONE
Name of the Attending Surgeon: SURSURGEON,TWO
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)
Select NON-OPERATIVE OCCURRENCES: SYSTEMIC SEPSIS
  Occurrence Category: SYSTEMIC SEPSIS
NSQIP Definition (2006):
  The body's response to insult can be documented as one of two levels
  with the successive level building on the previous level. You should
  only document the highest level identified using the criteria below.

  1. Sepsis: Sepsis is the systemic response to infection. Report this
  variable if the patient has clinical signs and symptoms of SIRS. SIRS is
  a widespread inflammatory response to a variety of severe clinical
  insults. This syndrome is clinically recognized by the presence of two
  or more of the following:
     - Temp >38 degrees C or <36 degrees C
     - HR >90 bpm
     - RR >20 breaths/min or PaCO2 <32 mmHg(<4.3 kPa)
     - WBC >12,000 cell/mm3, <4000 cells/mm3, or >10% immature (band)
       forms
     - Anion gap acidosis (this is defined by [sodium + potassium] -
       [chloride + CO2]. If this number is greater than 12, then an anion
       gap acidosis is present.

   and one of the following:
     - positive blood culture
     - clinical documentation of purulence at any site thought to be
       causative
```

```
  2. Severe Sepsis/Septic Shock: Sepsis is considered severe when it is
  associated with organ and/or circulatory dysfunction. Report this
  variable if the patient has the clinical signs and symptoms of SIRS or
  sepsis AND documented organ and/or circulatory dysfunction. Examples of
  organ dysfunction include: oliguria, acute alteration in mental status,
  acute respiratory distress. Examples of circulatory dysfunction include:
  hypotension, requirement of inotropic or vasopressor agents.

  * For the patient that had sepsis preoperatively, worsening of any of
  the above signs postoperatively would be reported as a postoperative
  sepsis.

  Examples:

  A patient comes into the emergency room with signs of sepsis - WBC 31,
  Temperature 104. CT shows an abdominal abscess. He is given antibiotics
  and is then taken emergently to the OR to drain the abscess. He receives
  antibiotics intraoperatively. Postoperatively his WBC and Temperature
  are trending down.
    POD#1 WBC 24, Temp 102
    POD#2 WBC 14, Temp 100
    POD#3 WBC 10, Temp 99
  This patient does not have postoperative sepsis as his WBC and
  Temperature are improving each postoperative day.

  Patient comes into the ER with s/s of sepsis - WBC 31, Temp 104. CT
  shows an abdominal abscess. He is given antibiotics and is taken
  emergently to the OR to drain the abscess. He receives antibiotics
  intraoperatively. Postoperatively his WBC and Temp are as follows:
    POD#1 WBC 28, Temp 103
    POD#2 WBC 24, Temp 102.6
    POD#3 WBC 22, Temp 102
    POD#4 WBC 21, Temp 101.6
    POD#5 WBC 30, Temp 104
  This patient does have postoperative sepsis because on postoperative day
  #5, his WBC and Temperature increase. The patient is having worsening of
  the defined signs of sepsis.

  Treatment Instituted: ANTIBIOTICS
  Outcome to Date: U  UNRESOLVED
  Occurrence Comments:
  1>Cancel scheduled surgery for this week. Reschedule later.
  2><Enter>
EDIT Option: <Enter>

Press RETURN to continue
```

(This page included for two-sided copying.)

Update Status of Returns Within 30 Days
[SRO UPDATE RETURNS]

The *Update Status of Returns Within 30 Days* option will define a case as related or unrelated to another case. When a new surgical case is entered into the software, the user is asked whether it is related to any previous cases within the past 30 days. This option is designed to update that information.

The user should first enter the patient name and select a case. The software will list any cases that occurred within 30 days prior to the selected case and will indicate if the listed cases have been flagged as related or unrelated. At this point the user may update the status of the cases listed.

Example: Updating Status of Returns Within 30 days

```
Select Perioperative Occurrences Menu Option:  Update Status of Returns Within 3
0 Days

Select Patient: SURPATIENT,SIXTY           03-03-59     000567821     NO     NO
N-VETERAN (OTHER)
```

```
SURPATIENT,SIXTY   000-56-7821

1. 07-06-99   REPAIR INGUINAL HERNIA (COMPLETED)

2. 06-25-99   CHOLECYSTECTOMY, APPENDECTOMY (COMPLETED)

3. 06-23-99   CHOLEDOCHOTOMY (COMPLETED)

4. 04-10-98   CRANIOTOMY (COMPLETED)



Select Operation: 3
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1999   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

1. 07/06/99    REPAIR INGUINAL HERNIA - UNRELATED

2. 06/25/99    CHOLECYSTECTOMY - UNRELATED

------------------------------------------------------------------------------


Select Number: 2
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1999   CHOLEDOCHOTOMY
------------------------------------------------------------------------------


2. 06/25/99    CHOLECYSTECTOMY - UNRELATED

------------------------------------------------------------------------------


This return to surgery is currently defined as UNRELATED to the case selected.
Do you want to change this status ? NO// Y
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1999   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------

1. 07/06/99    REPAIR INGUINAL HERNIA  - UNRELATED

2. 06/25/99    CHOLECYSTECTOMY  - RELATED

-------------------------------------------------------------------------------


Select Number:
```

Morbidity & Mortality Reports
[SROMM]

The *Morbidity & Mortality Reports* option generates two reports: the Perioperative Occurrences Report and the Mortality Report. The Perioperative Occurrences Report includes all cases that have occurrences, both intraoperatively and postoperatively, and can be sorted by specialty, attending surgeon, or occurrence category. The Mortality Report includes all cases performed within the selected date range that had a death within 30 days after surgery, and sort by specialty within a date range. Each surgical specialty will begin on a separate page.

After the user enters the date range, the software will ask whether to generate both reports. If the user answers **NO**, the software will ask the user to select from the Perioperative Occurrences Report or the Mortality Report.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Printing the Perioperative Occurrences Report – Sorted by Specialty

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 1

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

Do you want to print all divisions? YES// <Enter>

Print report by
 1. Surgical Specialty
 2. Attending Surgeon
 3. Occurrence Category

Select 1, 2 or 3:  (1-3): 1// <Enter>

Do you want to print this report for all Surgical Specialties ?  YES// N


Print the report for which Specialty ?  GENERAL (OR WHEN NOT DEFINED BELOW)
Select an Additional Specialty  <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

----------*report follows*----------

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
GENERAL(OR WHEN NOT DEFINED BELOW)			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
SURPATIENT,FOURTEEN 000-45-7212 JUL 31, 2006@09:00	CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (08/02/06) ANTIBIOTICS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Example 2: Printing the Perioperative Occurrences Report – Sorted by Attending Surgeon

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 1

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

Do you want to print all divisions? YES// <Enter>

Print report by
 1. Surgical Specialty
 2. Attending Surgeon
 3. Occurrence Category

Select 1, 2 or 3:  (1-3): 1// 2

Do you want to print this report for all Attending Surgeons ? YES//N

Print the report for which Attending Surgeon ? SURGEON,ONE

Select an Additional Attending Surgeon:  <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

----------*report follows*----------

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
ATTENDING: SURGEON,ONE			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
SURPATIENT,THREE 000-21-2453 JUL 22, 2006@10:00	CARDIAC SURGERY CABG	REPEAT VENTILATOR SUPPORT W/IN 30 DAYS *	I
SURPATIENT,FOURTEEN 000-45-7212 JUL 31, 2006@09:00	CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (08/02/06) ANTIBIOTICS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Example 3: Printing the Perioperative Occurrences Report – Sorted by Occurrence Category

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 1

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

Do you want to print all divisions? YES// <Enter>

Print report by
 1. Surgical Specialty
 2. Attending Surgeon
 3. Occurrence Category

Select 1, 2 or 3:  (1-3): 1// 3

Do you want to print this report for all occurrence categories? YES// NO

Print the report for which Occurrence Category ? ACUTE RENAL FAILURE
  NSQIP Definition (2006):
  In a patient who did not require dialysis preoperatively, worsening of
  renal dysfunction (increase in serum creatinine to >2.0 and two times
  most recent preoperative creatinine level) and postoperatively
  requiring hemodialysis, peritoneal dialysis, hemofiltration,
  hemodiafiltration or ultrafiltration.

  TIP: If the patient refuses dialysis report as an occurrence because
  he/she did require dialysis.

  CICSP Definition (2004):
  Indicate if the patient developed new renal failure requiring dialysis
  or experienced an exacerbation of preoperative renal failure requiring
  initiation of dialysis (not on dialysis preoperatively) within 30 days
  postoperatively.

Select an Additional Occurrence Category:  <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

----------*report follows*----------

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	ATTENDING SURGEON / SURGICAL SPECIALTY / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
CATEGORY: ACUTE RENAL FAILURE			
SURPATIENT,SEVENTEEN 000-45-5119 JUL 18, 2006@07:15	SURGEON,TWO GENERAL REPAIR INCARCERATED INGUINAL HERNIA	ACUTE RENAL FAILURE DIALYSIS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Example 4: Printing the *Mortality Report*

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 2

Start with Date: 1/1/06  (JAN 01, 2006)
End with Date: 7/31/06  (JUL 31, 2006)

Do you want to print all divisions? YES// <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

----------*report follows*----------

SURGICAL SERVICE REVIEWED BY:
MORTALITY REPORT DATE REVIEWED:
FROM: JAN 1,2006 TO: JUL 31,2006 DATE PRINTED: AUG 22,2006

OPERATION DATE	PATIENT ID#	PRINCIPAL OPERATIVE PROCEDURE	DATE OF DEATH AUTOPSY (Y/N)
		OTORHINOLARYNGOLOGY (ENT)	
JAN 22, 2006	SURPATIENT,SIXTEEN 000-11-1111	LARYNGOSCOPY, BRONCHOSCOPY, ESOPHAGOGASTROSCOPY	FEB 09, 2006 NO
JAN 27, 2006	SURPATIENT,TWO 000-45-1982	BRONCHOSCOPY	FEB 26, 2006 NOT AVAILABLE
JAN 29, 2006	SURPATIENT,SIXTEEN 000-11-1111	BILATERAL NECK DISECTION, LARYNGECTOMY	FEB 09, 2006 NO
FEB 08, 2006	SURPATIENT,SIXTEEN 000-11-1111	LIGATION LT INTERNAL JUGLAR , EXPLORATORY LAPARATOMY	FEB 09, 2006 NO
FEB 19, 2006	SURPATIENT,TEN 000-12-3456	TRACH	FEB 21, 2006 NO
JUL 20, 2006	SURPATIENT,FORTY 000-77-7777	LARYNGOSCOPY W/ BX, ESOPHAGOSCOPY	NOV 01, 2006 NOT AVAILABLE

Nurse Intraoperative Report
[SRCODING NURSE REPORT]

The *Nurse Intraoperative Report* option is used by the coders to print the Nurse Intraoperative Report for an operation. This report is not available for non-O.R. procedures.

This report prints in an 80-column format and can be viewed on the screen or copied to a printer.

Example: Nurse Intraoperative Report

```
Select CPT/ICD9 Update/Verify Menu Option: NR  Nurse Intraoperative Report
DEVICE: [Select Print Device]
```

----------*printout follows*----------

```
------------------------------------------------------------------------------
SURPATIENT,TEN  000-12-3456                        NURSE INTRAOPERATIVE REPORT
------------------------------------------------------------------------------
NOTE DATED: 02/12/2002 08:00  NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room:  BO OR1                Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004  07:30    Patient in OR:  JUL 12, 2004  08:00
Operation Begin: JUL 12, 2004  08:58    Operation End:  JUL 12, 2004  12:10
Surgeon in OR:   JUL 12, 2004  07:55    Patient Out OR: JUL 12, 2004  12:15

Major Operations Performed:
Primary: MVR
Other:   ATRIAL SEPTAL DEFECT REPAIR
Other:   TEE

Wound Classification: CONTAMINATED

Operation Disposition: SICU
Discharged Via: ICU BED

Surgeon: SURSURGEON,THREE              First Assist: SURSURGEON,FOUR
Attend Surg: SURSURGEON,THREE          Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN            Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:
  Scrubbed                             Circulating
 SURNURSE,ONE (FULLY TRAINED)          SURNURSE,FIVE (FULLY TRAINED)
                                       SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood:       ANXIOUS              Preop Consc:    ALERT-ORIENTED
Preop Skin Integ: INTACT               Preop Converse: N/A

Valid Consent/ID Band Confirmed By: SURSURGEON,FOUR
Mark on Surgical Site Confirmed: YES
  Marked Site Comments: NO COMMENTS ENTERED

Preoperative Imaging Confirmed: YES
  Imaging Confirmed Comments: NO COMMENTS ENTERED

Time Out Verification Completed: YES
  Time Out Verified Comments: NO COMMENTS ENTERED

Skin Prep By: SURNURSE,FOUR             Skin Prep Agent: BETADINE SCRUB
Skin Prep By (2): SURNURSE,FIVE         2nd Skin Prep Agent: POVIDONE IODINE

Preop Surgical Site Hair Removal by: SURNURSE,FIVE
Surgical Site Hair Removal Method: OTHER
  Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):
  SUPINE                               Placed: N/A

Restraints and Position Aids:
  SAFETY STRAP                    Applied By: N/A
  ARMBOARD                        Applied By: N/A
  FOAM PADS                       Applied By: N/A
  KODEL PAD                       Applied By: N/A
  STIRRUPS                        Applied By: N/A

Electrocautery Unit:       8845,5512
ESU Coagulation Range:     50-35
```

```
ESU Cutting Range:         35-35
Electroground Position(s): RIGHT BUTTOCK
                           LEFT BUTTOCK

Material Sent to Laboratory for Analysis:
Specimens:
 1. MITRAL VALVE
Cultures:  N/A

Anesthesia Technique(s):
 GENERAL  (PRINCIPAL)


Tubes and Drains:
  #16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
  Item: MITRAL VALVE
    Vendor: BAXTER EDWARDS
    Model: 6900
    Lot/Serial Number: GY0755                       Sterile Resp: MANUFACTURER
    Size: 29MM                                      Quantity: 1

Medications: N/A

Irrigation Solution(s):
  HEPARINIZED SALINE
  NORMAL SALINE
  COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count:       YES
Sharps Count:       YES
Instrument Count:   NOT APPLICABLE
Counter:            SURNURSE,FOUR
Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing:  NONE

Blood Loss: 800 ml                     Urine Output: 750 ml

Postoperative Mood:           RELAXED
Postoperative Consciousness:  ANESTHETIZED
Postoperative Skin Integrity: SUTURED INCISION
Postoperative Skin Color:     N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

                 Signed by: /es/ FIVE SURNURSE
                                 03/04/2002 10:41
```

Non-OR Procedure Information
[SR NON-OR INFO]

The *Non-OR Procedure Information* option displays information on the selected non-OR procedure, with the exception of the provider's dictated summary.

This report prints in an 80-column format and can be viewed on the screen.

Example: Non-OR Procedure Information

```
SURPATIENT,FIFTEEN (000-98-1234)   Case #267260 - APR 22,2002


   UV     Update/Verify Procedure/Diagnosis Codes
   OR     Operation/Procedure Report
   NR     Nurse Intraoperative Report
   PI     Non-OR Procedure Information

Select CPT/ICD9 Update/Verify Menu Option: I  Non-O.R. Procedure Information

DEVICE: HOME// [Select Print Device]

-----------------------------------printout follows---------------------------------

SURPATIENT,FIFTEEN (000-98-1234)  Age: 60                                   PAGE 1
NON-O.R. PROCEDURE - CASE #267260                 Printed: AUG 04, 2004@14:40
-------------------------------------------------------------------------------

Med. Specialty: GENERAL                     Location: NON OR

Principal Diagnosis: LARYNGEAL/TRACHEAL BURN

Provider: SURSURGEON,FIFTEEN                     Patient Status: NOT ENTERED
Attending:
Attending Code:

Attend Anesth: N/A
Anesthesia Supervisor Code: N/A
Anesthetist: N/A

Anesthesia Technique(s): N/A

Proc Begin:  JAN 14, 2004  08:00        Proc End:  JAN 14, 2004  09:00

Procedure(s) Performed:
  Principal: BRONCHOSCOPY


Dictated Summary Expected: YES

Enter RETURN to continue or '^' to exit:
```

Management Reports
[SRO-CHIEF REPORTS]

The *Management Reports* menu is designed to give the Chief of Surgery various management reports. The reports contained on this menu are listed below. To the left of the option/report name is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
MM	*Morbidity & Mortality Reports*
MV	*M&M Verification Report*
CD	*Comparison of Preop and Postop Diagnosis*
D	*Delay and Cancellation Reports ...*
V	*List of Unverified Surgery Cases*
RET	*Report of Returns to Surgery*
A	*Report of Daily Operating Room Activity*
NS	*Report of Cases Without Specimens*
ICU	*Report of Unscheduled Admissions to ICU*
OR	*Operating Room Utilization Report*
WC	*Wound Classification Report*
QM	*Quarterly Report Menu ...*
BA	*Print Blood Product Verification Audit Log*
ECS	*Ensuring Correct Surgery Compliance Report*

Morbidity & Mortality Reports

[SROMM]

The *Morbidity & Mortality Reports* option generates two reports: the Perioperative Occurrences Report and the Mortality Report. The Perioperative Occurrences Report includes all cases that have occurrences, both intraoperatively and postoperatively, and can be sorted by specialty, attending surgeon, or occurrence category. The Mortality Report includes all cases performed within the selected date range that had a death within 30 days after surgery, and sort by specialty within a date range. Each surgical specialty will begin on a separate page.

After the user enters the date range, the software will ask whether to generate both reports. If the user answers **NO**, the software will ask the user to select from the Perioperative Occurrences Report or the Mortality Report.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Printing the Perioperative Occurrences Report – Sorted by Specialty

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 1

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

Do you want to print all divisions? YES// <Enter>

Print report by
 1. Surgical Specialty
 2. Attending Surgeon
 3. Occurrence Category

Select 1, 2 or 3:  (1-3): 1// <Enter>

Do you want to print this report for all Surgical Specialties ?  YES// N


Print the report for which Specialty ?  GENERAL (OR WHEN NOT DEFINED BELOW)
Select an Additional Specialty  <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

----------*report follows*----------

SURGICAL SERVICE
PERIOPERATIVE OCCURRENCES
FROM: JUL 1,2006 TO: JUL 31,2006

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
GENERAL(OR WHEN NOT DEFINED BELOW)			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
SURPATIENT,FOURTEEN 000-45-7212 JUL 31, 2006@09:00	CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (08/02/06) ANTIBIOTICS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Example 2: Printing the Perioperative Occurrences Report – Sorted by Attending Surgeon

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 1

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

Do you want to print all divisions? YES// <Enter>

Print report by
 1. Surgical Specialty
 2. Attending Surgeon
 3. Occurrence Category

Select 1, 2 or 3:  (1-3): 1// 2

Do you want to print this report for all Attending Surgeons ? YES//N

Print the report for which Attending Surgeon ? SURGEON,ONE

Select an Additional Attending Surgeon:  <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

----------*report follows*----------

SURGICAL SERVICE
PERIOPERATIVE OCCURRENCES
FROM: JUL 1,2006 TO: JUL 31,2006

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
ATTENDING: SURGEON,ONE			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
SURPATIENT,THREE 000-21-2453 JUL 22, 2006@10:00	CARDIAC SURGERY CABG	REPEAT VENTILATOR SUPPORT W/IN 30 DAYS *	I
SURPATIENT,FOURTEEN 000-45-7212 JUL 31, 2006@09:00	CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (08/02/06) ANTIBIOTICS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Example 3: Printing the Perioperative Occurrences Report – Sorted by Occurrence Category

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 1

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

Do you want to print all divisions? YES// <Enter>

Print report by
 1. Surgical Specialty
 2. Attending Surgeon
 3. Occurrence Category

Select 1, 2 or 3:  (1-3): 1// 3

Do you want to print this report for all occurrence categories? YES// NO

Print the report for which Occurrence Category ? ACUTE RENAL FAILURE
  NSQIP Definition (2006):
  In a patient who did not require dialysis preoperatively, worsening of
  renal dysfunction (increase in serum creatinine to >2.0 and two times
  most recent preoperative creatinine level) and postoperatively
  requiring hemodialysis, peritoneal dialysis, hemofiltration,
  hemodiafiltration or ultrafiltration.

  TIP: If the patient refuses dialysis report as an occurrence because
  he/she did require dialysis.

  CICSP Definition (2004):
  Indicate if the patient developed new renal failure requiring dialysis
  or experienced an exacerbation of preoperative renal failure requiring
  initiation of dialysis (not on dialysis preoperatively) within 30 days
  postoperatively.

Select an Additional Occurrence Category:  <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

----------*report follows*----------

SURGICAL SERVICE
PERIOPERATIVE OCCURRENCES
FROM: JUL 1,2006 TO: JUL 31,2006

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	ATTENDING SURGEON / SURGICAL SPECIALTY / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
CATEGORY: ACUTE RENAL FAILURE			
SURPATIENT,SEVENTEEN 000-45-5119 JUL 18, 2006@07:15	SURGEON,TWO GENERAL REPAIR INCARCERATED INGUINAL HERNIA	ACUTE RENAL FAILURE DIALYSIS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Example 4: Print the Mortality Report

```
Select Management Reports Option:  MM Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 2

Start with Date: 1/1/06  (JAN 01, 2006)
End with Date: 7/31/06  (JUL 31, 2006)


Do you want to print all divisions? YES// <Enter>

This report is designed to use a 132 column format.

Print report on which Device: [Select Print Device]
```

----------*printout follows*----------

SURGICAL SERVICE REVIEWED BY:
MORTALITY REPORT DATE REVIEWED:
FROM: JAN 1,2006 TO: JUL 31,2006 DATE PRINTED: AUG 22,2006

OPERATION DATE	PATIENT ID#	PRINCIPAL OPERATIVE PROCEDURE	DATE OF DEATH AUTOPSY (Y/N)
		OTORHINOLARYNGOLOGY (ENT)	
JAN 22, 2006	SURPATIENT,SIXTEEN 000-11-1111	LARYNGOSCOPY, BRONCHOSCOPY, ESOPHAGOGASTROSCOPY	FEB 09, 2006 NO
JAN 27, 2006	SURPATIENT,TWO 000-45-1982	BRONCHOSCOPY	FEB 26, 2006 NOT AVAILABLE
JAN 29, 2006	SURPATIENT,SIXTEEN 000-11-1111	BILATERAL NECK DISECTION, LARYNGECTOMY	FEB 09, 2006 NO
FEB 08, 2006	SURPATIENT,SIXTEEN 000-11-1111	LIGATION LT INTERNAL JUGLAR , EXPLORATORY LAPARATOMY	FEB 09, 2006 NO
FEB 19, 2006	SURPATIENT,TEN 000-12-3456	TRACH	FEB 21, 2006 NO
JUL 20, 2006	SURPATIENT,FORTY 000-77-7777	LARYNGOSCOPY W/ BX, ESOPHAGOSCOPY	NOV 01, 2006 NOT AVAILABLE

M&M Verification Report

[SRO M&M VERIFICATION REPORT]

The *M&M Verification Report* option produces the M&M Verification Report that may be useful for (1) reviewing occurrences and their assignments to operations and (2) reviewing deaths unrelated/related assignments to operations

Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range and experienced intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk-assessed operations that are in a completed state but have not yet been transmitted to the national database.

Variety #1: Report information is printed patient-by-patient, listing all operations for the patient that occurred during the selected date range, as well as any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that were performed prior to the selected date range, and, if printed by specialty, may include operations performed by other specialties. For every operation that is listed, the intraoperative and postoperative occurrences are also listed. The report also includes information about whether the operation was unrelated or related to death as well as the risk assessment type and status (if assessed). The report may be printed for a selected list of surgical specialties.

Variety #2: Report information is printed patient-by-patient in a format similar to Variety #1. This report lists all risk-assessed operations that are in a completed state but have not yet been transmitted to the national database and that have intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The report includes any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some other operations that may or may not be risk assessed, and, if risk assessed, may have any risk assessment status (incomplete, complete, or transmitted). Every patient listed on this report will have at least one operation with a risk assessment status of "complete."

Example 1: Generate an M&M Verification Report (Full Report)

```
Select Management Reports Option: MV  M&M Verification Report

                            M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences
and their assignments to operations and in the review of death unrelated or
related assignments to operations. Two varieties of this report are available.
The first variety provides a report of all patients who had operations within
the selected date range who experienced intraoperative occurrences,
postoperative occurrences, or death within 90 days of surgery. The second
variety provides a similar report for all risk assessed operations that are in
a completed state but have not yet transmitted to the national database.


Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// <Enter>

Start with Date: 12 31 01  (DEC 31, 2001)
End with Date: 1 31 02  (JAN 31, 2002)
```

Hospital: MAYBERRY, NC
Station Number: 999
For Dates: JUN 01, 2004 to: JUN 30, 2004

ENSURING CORRECT SURGERY - COMPLIANCE SUMMARY

	CASES	% OF TOTAL
TOTAL CASES PERFORMED:	315	100.0
TIME OUT VERIFIED		
YES:	308	97.8
NO:	5	1.6
NOT ENTERED:	2	0.6
PREOPERATIVE IMAGING CONFIRMED		
YES:	219	69.5
IMAGING NOT REQUIRED:	88	27.9
NO:	5	1.6
NOT ENTERED:	3	1.0
MARK ON SURGICAL SITE CONFIRMED		
YES:	219	69.5
MARKING NOT REQUIRED:	6	1.7
NO:	2	0.6
NOT ENTERED:	1	.4

OVERALL COMPLIANCE FOR THIS DATE RANGE

TIME OUT VERIFIED:	97.8%
PREOPERATIVE IMAGING CONFIRMED:	97.4%
MARK ON SURGICAL SITE CONFIRMED:	97.4%

PREOPERATIVE HAIR REMOVAL METHODS SUMMARY

	CASES	% OF TOTAL
TOTAL CASES PERFORMED:	36	100.0
CLIPPER:	2	5.6
DEPILATORY:	10	27.8
NO HAIR REMOVED:	1	2.8
PATIENT REMOVED OWN HAIR:	3	8.3
SHAVING:	1	2.8
NOT DOCUMENTED:	17	47.2
OTHER:	2	5.6

Example 2: Quarterly Report for Surgical Service

```
Select Management Reports Option: Q  Quarterly Report - Surgical Specialty

QUARTERLY/SUMMARY REPORT FOR SURGICAL SERVICE

NOTE:  Listed below are the CPT codes for the index procedures on these reports.

    Procedure                CPT Code(s)
    ---------                -----------
    Inguinal Hernia          49505,49507,49520,49521,49525
    Cholecystectomy          47600,47605,47610,56340,56341,56342
    Coronary Artery Bypass   33510,33511,33512,33513,33514,33516,33517,33518,
                             33519,33521,33522,33523,33533,33534,33535,33536
    Colon Resection (L & R)  44140,44141,44143,44144,44145,44146,44147,44160
    Fem-Pop Bypass           35656,35556
    Pulmonary Lobectomy      32480,32500,32440
    Hip Replacement
      - Elective             27125,27130,27132,27134,27137,27138
      - Acute Fracture       27236
    TURP                     52601
    Laryngectomy             31360,31365,31367,31368
    Craniotomy               61304,61305,61312,61314,61510,61512,61518,61519,
                             61700,61680
    Intraoccular Lens        66983,66984

Press RETURN to continue or '^' to quit: <Enter>

Run which report ?

   1. Summary Report for Selected Date Range
   2. Quarterly Report for Central Office

Select Report Number:  1// 2
```

```
QUARTERLY REPORT FOR SURGICAL SERVICE

Run report for which quarter of the fiscal year ?

     (1) October 1 - December 31
     (2) January 1 - March 31
     (3) April 1 - June 30
     (4) July 1 - September 30

Select Quarter:  3

Select FISCAL YEAR: 2004// <Enter>

Do you want this report to be transmitted to the Surgical Service
central database ?  NO// <Enter>

Print report on which Device: [Select Print Device]
```

----------*printout follows*----------

Hospital: MAYBERRY, NC Station Number: 999
For Dates: APR 01, 2004 to: JUN 30, 2004 Fiscal Year: 2004

ENSURING CORRECT SURGERY - COMPLIANCE SUMMARY

	CASES	% OF TOTAL
TOTAL CASES PERFORMED:	1315	100.0
TIME OUT VERIFIED		
YES:	1140	86.7
NO:	13	1.0
NOT ENTERED:	162	12.3
PREOPERATIVE IMAGING CONFIRMED		
YES:	543	41.3
IMAGING NOT REQUIRED:	427	32.5
NO:	6	0.5
NOT ENTERED:	339	25.8
MARK ON SURGICAL SITE CONFIRMED		
YES:	543	41.3
MARKING NOT REQUIRED:	427	32.5
NO:	6	0.5
NOT ENTERED:	339	25.8

OVERALL COMPLIANCE FOR THIS DATE RANGE

TIME OUT VERIFIED:	86.7%
PREOPERATIVE IMAGING CONFIRMED:	73.8%
MARK ON SURGICAL SITE CONFIRMED:	73.8%

PREOPERATIVE HAIR REMOVAL METHODS SUMMARY

	CASES	% OF TOTAL
TOTAL CASES PERFORMED:	36	100.0
CLIPPER:	2	5.6
DEPILATORY:	10	27.8
NO HAIR REMOVED:	1	2.8
PATIENT REMOVED OWN HAIR:	3	8.3
SHAVING:	1	2.8
NOT DOCUMENTED:	17	47.2
OTHER:	2	5.6

Deaths Within 30 Days of Surgery
[SROQD]

The *Deaths Within 30 Days of Surgery* option lists patients who had surgery within the selected date range, died within 30 days of surgery and whose deaths are included on the Quarterly/Summary Report. Three separate reports are available through this option. These reports correspond to the three sections of the Quarterly Report that include death totals.

1. **Total Cases Summary**: This report may be printed in one of three ways.

   A. All Cases

   The report will list all patients who had surgery within the selected date range and who died within 30 days of surgery, along with all of the patients' operations that were performed during the selected date range. These patients are included in the postoperative deaths totals on the Quarterly Report.

   B. Outpatient Cases Only

   The report will list only the surgical cases that are associated with deaths that are counted as outpatient (ambulatory) deaths on the Quarterly Report.

   C. Inpatient Cases Only

   The report will list only the surgical cases that are associated with deaths that are counted as inpatient deaths. Although the count of deaths associated with inpatient cases is not a part of the Quarterly Report, this report is provided to help with data validation.

2. **Specialty Procedures**: This report will list the surgical cases that are associated with deaths that are counted for the national surgical specialty linked to the local surgical specialty. Cases are listed by national surgical specialty.

3. **Index Procedures**: This report will list the surgical cases that are associated with deaths that are counted in the Index Procedures section of the Quarterly Report.

These reports have a 132-column format and are designed to be copied to a printer.

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                PAGE: 1 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
1. GENERAL:                                3. HEPATOBILIARY:
  A. Height:                  65 INCHES      A. Ascites:
  B. Weight:                   140 LBS.
  C. Diabetes Mellitus:                    4. GASTROINTESTINAL:
  D. Current Smoker W/I 1 Year:              A. Esophageal Varices:
  E. Pack/Years:
  F. ETOH > 2 Drinks/Day:                  5. CARDIAC:
  G. Dyspnea:                                A. CHF Within 1 Month:
  H. DNR Status:                             B. MI Within 6 Months:
  I. Pre-illness Funct Status:               C. Previous PCI:
  J. Preop Funct Status:                     D. Previous Cardiac Surgery:
                                             E. Angina Within 1 Month:
2. PULMONARY:                                F. Hypertension Requiring Meds:
  A. Ventilator Dependent:
  B. History of Severe COPD:               6. VASCULAR:
  C. Current Pneumonia:                      A. Revascularization/Amputation:
                                             B. Rest Pain/Gangrene:
-------------------------------------------------------------------------------

Select Preoperative Information to Edit: 1:3
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------


GENERAL: YES
```

```
Patient's Height 65 INCHES//: 62
Patient's Weight 140 POUNDS//: 175
Diabetes Mellitus Requiring Therapy With Oral Agents or Insulin: I  INSULIN
Current Smoker: Y  YES
Pack/Year Cigarette History: ??
        NSQIP Definition (2004):
        If the patient has ever been a smoker, enter the total number of
        pack/years of smoking for this patient. Pack-years are defined as the
        number of packs of cigarettes smoked per day times the number of years
        the patient has smoked. If the patient has never been a smoker, enter
        "0". If pack-years are >200, just enter 200. If smoking history cannot
        be determined, enter "NS". The possible range for number of pack-years
        is 0 to 200. If the chart documents differing values for pack year
        cigarette history, or ranges for either packs/day or number of years
        patient has smoked, select the highest value documented, unless you are
        confident in a particular documenter's assessment (e.g., preoperative
        anesthesia evaluation often includes a more accurate assessment of this
        value because of the impact it may have on the patient's response to
        anesthesia).


Pack/Year Cigarette History: 25
ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: N  NO
Dyspnea: N
     1   NO
     2   NO STUDY
Choose 1-2: 1  NO
DNR Status (Y/N): N  NO
Functional Health Status at Evaluation for Surgery: 1  INDEPENDENT
Functional Health Status Prior to Current Illness: 1  INDEPENDENT

PULMONARY: NO

HEPATOBILIARY: NO
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                PAGE: 1 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
1. GENERAL:                      YES      3. HEPATOBILIARY:                  NO
  A. Height:                  62 INCHES     A. Ascites:                       NO
  B. Weight:                   175 LBS.
  C. Diabetes Mellitus:         INSULIN  4. GASTROINTESTINAL:
  D. Current Smoker W/I 1 Year: YES        A. Esophageal Varices:
  E. Pack/Years:                25
  F. ETOH > 2 Drinks/Day:       NO       5. CARDIAC:
  G. Dyspnea:                   NO         A. CHF Within 1 Month:
  H. DNR Status:                NO         B. MI Within 6 Months:
  I. Preop Funct Status:       INDEPENDENT C. Previous PTCA:
  J. Pre-illness Funct Status: INDEPENDENT D. Previous Cardiac Surgery:
                                           E. Angina Within 1 Month:
2. PULMONARY:                    NO         F. Hypertension Requiring Meds:
  A. Ventilator Dependent:       NO
  B. History of Severe COPD:     NO       6. VASCULAR:
  C. Current Pneumonia:          NO         A. Revascularization/Amputation:
                                           B. Rest Pain/Gangrene:
-------------------------------------------------------------------------------

Select Preoperative Information to Edit: <Enter>
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                PAGE: 2 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------

1. RENAL:                              3. NUTRITIONAL/IMMUNE/OTHER:
  A. Acute Renal Failure:                A. Disseminated Cancer:
  B. Currently on Dialysis:              B. Open Wound:
                                         C. Steroid Use for Chronic Cond.:
2. CENTRAL NERVOUS SYSTEM:               D. Weight Loss > 10%:
  A. Impaired Sensorium:                 E. Bleeding Disorders:
  B. Coma:                               F. Transfusion > 4 RBC Units:
  C. Hemiplegia:                         G. Chemotherapy W/I 30 Days:
  D. History of TIAs:                    H. Radiotherapy W/I 90 Days:
  E. CVA/Stroke w. Neuro Deficit:        I. Preoperative Sepsis:
  F. CVA/Stroke w/o Neuro Deficit:       J. Pregnancy
  G. Tumor Involving CNS:
  H. Paraplegia:
  I. Quadriplegia:

-------------------------------------------------------------------------------
Select Preoperative Information to Edit: 3E
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------

History of Bleeding Disorders (Y/N): Y  YES
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                PAGE: 2 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------

1. RENAL:                              3. NUTRITIONAL/IMMUNE/OTHER:
  A. Acute Renal Failure:                A. Disseminated Cancer:
  B. Currently on Dialysis:              B. Open Wound:
                                         C. Steroid Use for Chronic Cond.:
2. CENTRAL NERVOUS SYSTEM:               D. Weight Loss > 10%:
  A. Impaired Sensorium:                 E. Bleeding Disorders:            YES
  B. Coma:                               F. Transfusion > 4 RBC Units:
  C. Hemiplegia:                         G. Chemotherapy W/I 30 Days:
  D. History of TIAs:                    H. Radiotherapy W/I 90 Days:
  E. CVA/Stroke w. Neuro Deficit:        I. Preoperative Sepsis:
  F. CVA/Stroke w/o Neuro Deficit:       J. Pregnancy
  G. Tumor Involving CNS:
  H. Paraplegia:
  I. Quadriplegia:

-------------------------------------------------------------------------------
Select Preoperative Information to Edit:
```

Laboratory Test Results (Enter/Edit)
[SROA LAB]

Use the *Laboratory Test Results (Enter/Edit)* option to enter or edit preoperative and postoperative lab information for an individual risk assessment. The option is divided into the three features listed below. The first two features allow the user to merge (also called "capture" or "load") lab information into the risk assessment from the VistA software. The third feature provides a two-page summary of the lab profile and allows direct editing of the information.

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results

To "capture" preoperative lab data, the user must provide both the date and time the operation began. Likewise, to capture postoperative lab data, the user must provide both the date and time the operation was completed. If this information has already been entered, the system will not prompt for it again.

If assistance is needed while interacting with the software, entering one or two question marks (**??**) will access the on-line help.

Example 1: Capture Preoperative Laboratory Information

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: LAB  Laboratory Test Results
(Enter/Edit)
```

```
SURPATIENT,FORTY (000-77-7777)        Case #68112
SEP 19, 2003   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

Enter/Edit Laboratory Test Results

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results

Select Number: 1

This selection loads the most recent lab data for tests performed within 90 days before the
operation.
```

```
Do you want to automatically load preoperative lab data ?  YES// <Enter>

The 'Time Operation Began' must be entered before continuing.

Do you want to enter 'Time Operation Began' at this time ?  YES//  <Enter>

Time the Operation Began:  8:00  (SEP 25, 2003@08:00)

..Searching lab record for latest preoperative test data….

..Moving preoperative lab test data to Surgery Risk Assessment file….

Press <RET> to continue  <Enter>
```

Example 2: Capture Postoperative Laboratory Information

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: LAB  Laboratory Test Results
(Enter/Edit)

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results


Select Number: 2

This selection loads highest or lowest lab data for tests performed within 30 days after the
operation.

Do you want to automatically load postoperative lab data ?  YES// <Enter>

'Time the Operation Ends' must be entered before continuing.

Do you want to enter the time that the operation was completed at
this time ?  YES//   <Enter>

Time the Operation Ends: 12:00  (SEP 25, 2003@12:00)

..Searching lab record for postoperative lab test data….

..Moving postoperative lab data to Surgery Risk Assessment file….

Press <RET> to continue
```

Example 3: Enter, Edit, or Review Laboratory Test Results

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: LAB  Laboratory Test Results
(Enter/Edit)

Enter/Edit Laboratory Test Results

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results

Select Number: 3

SURPATIENT,FORTY (000-77-7777)        Case #68112                  PAGE: 1 OF 2
LATEST PREOP LAB RESULTS IN 90 DAYS PRIOR TO SURGERY  UNLESS OTHERWISE SPECIFIED
SEP 19,2003   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

 1. Anion Gap (in 48 hrs.):   12    (SEP 18,2003)
 2. Serum Sodium:             139   (SEP 18,2003)
 3. BUN:                      13    (SEP 18,2003)
 4. Serum Creatinine:         1     (SEP 18,2003)
 5. Serum Albumin:            4     (SEP 18,2003)
 6. Total Bilirubin:          .8    (SEP 18,2003)
 7. SGOT:                     29    (SEP 18,2003)
 8. Alkaline Phosphatase:     120   (SEP 18,2003)
 9. WBC:                      12.8  (SEP 18,2003)
10. Hematocrit:               45.7  (SEP 18,2003)
11. Platelet Count:           NS
12. PTT:                      NS
13. PT:                       NS
14. INR:                      NS
------------------------------------------------------------------------------

Select Preoperative Laboratory Information to Edit: 11:13
```

```
SURPATIENT,FORTY (000-77-7777)        Case #68112
SEP 19,2003   CHOLEDOCHOTOMY
--------------------------------------------------------------------------------

Preoperative Platelet Count (X 1000/mm3): 289
Date Preoperative Platelet Count was Performed: 9/18/03  (SEP 18, 2003)
Preoperative PTT (seconds): 33.7
Date Preoperative PTT was Performed: 9/18/03  (SEP 18, 2003)
Preoperative PT (seconds): 11.8
Date Preoperative PT was Performed: 9/18/03  (SEP 18, 2003)
```

```
SURPATIENT,FORTY (000-77-7777)        Case #68112                  PAGE: 1 OF 2
LATEST PREOP LAB RESULTS IN 90 DAYS PRIOR TO SURGERY  UNLESS OTHERWISE SPECIFIED
SEP 19,2003   CHOLEDOCHOTOMY
--------------------------------------------------------------------------------

 1. Anion Gap (in 48 hrs.):   12    (SEP 18,2003)
 2. Serum Sodium:             139   (SEP 18,2003)
 3. BUN:                      13    (SEP 18,2003)
 4. Serum Creatinine:          1    (SEP 18,2003)
 5. Serum Albumin:             4    (SEP 18,2003)
 6. Total Bilirubin:          .8    (SEP 18,2003)
 7. SGOT:                     29    (SEP 18,2003)
 8. Alkaline Phosphatase:     120   (SEP 18,2003)
 9. WBC:                      12.8  (SEP 18,2003)
10. Hematocrit:               45.7  (SEP 18,2003)
11. Platelet Count:           289   (SEP 18,2003)
12. PTT:                      33.7  (SEP 18,2003)
13. PT:                       11.8  (SEP 18,2003)
14. INR:                      NS
--------------------------------------------------------------------------------

Select Preoperative Laboratory Information to Edit:  <Enter>
```

```
SURPATIENT,FORTY (000-77-7777)        Case #68112                  PAGE: 2 OF 2
POSTOP LAB RESULTS WITHIN 30 DAYS AFTER SURGERY
SEP 19,2003   CHOLEDOCHOTOMY
--------------------------------------------------------------------------------

 1. Highest Anion Gap:             12        (SEP 20,2003)
 2. Highest Serum Sodium:          139       (SEP 20,2003)
 3. Lowest Serum Sodium:           135       (SEP 20,2003)
 4. Highest Potassium:             4.4       (SEP 20,2003)
 5. Lowest Potassium:              3.4       (SEP 20,2003)
 6. Highest Serum Creatinine:      1.2       (SEP 20,2003)
 7. Highest CPK:                   NS
 8. Highest CPK-MB Band:           NS
 9. Highest Total Bilirubin:       NS
10. Highest WBC:                   11.8      (SEP 20,2003)
11. Lowest Hematocrit:             40.3      (SEP 20,2003)
12. Highest Troponin I:            10.18     (SEP 24,2003)
13. Highest Troponin T:            12.13     (SEP 24,2003)

--------------------------------------------------------------------------------

Select Postoperative Laboratory Information to Edit: 2
```

```
SURPATIENT,FORTY (000-77-7777)        Case #68112
SEP 19,1998   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

Highest Postoperative Serum Sodium: 139// 144
Date Highest Serum Sodium was Recorded: 9/21/03  (SEP 21, 2003)
```

```
SURPATIENT,FORTY (000-77-7777)        Case #68112                     PAGE: 2 OF 2
POSTOP LAB RESULTS WITHIN 30 DAYS AFTER SURGERY
SEP 19,2003   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

 1. Highest Anion Gap:             12        (SEP 20,2003)
 2. Highest Serum Sodium:          144       (SEP 21,2003)
 3. Lowest Serum Sodium:           135       (SEP 20,2003)
 4. Highest Potassium:             4.4       (SEP 20,2003)
 5. Lowest Potassium:              3.4       (SEP 20,2003)
 6. Highest Serum Creatinine:      1.2       (SEP 20,2003)
 7. Highest CPK:                   NS
 8. Highest CPK-MB Band:           NS
 9. Highest Total Bilirubin:       NS
10. Highest WBC:                   11.8      (SEP 20,2003)
11. Lowest Hematocrit:             40.3      (SEP 20,2003)
12. Highest Troponin I:            10.18     (SEP 24,2003)
13. Highest Troponin T:            12.13     (SEP 24,2003)

------------------------------------------------------------------------------

Select Postoperative Laboratory Information to Edit:
```

Operation Information (Enter/Edit)
[SROA OPERATION DATA]

The *Operation Information (Enter/Edit)* option is used to enter or edit information related to the operation. At the bottom of each page is a prompt to select one or more operative items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will exit the option. If they are not already there, it is important that the operation's beginning and ending times be entered so that the user can later enter postoperative information.

About the "Select Operative Information to Edit:" Prompt

The user should first enter the item number to edit at the "Select Operative Information to Edit:" prompt. To respond to every item on the page, the user should enter **A** for **ALL** or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information has been entered or edited, the display will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data. If information has been entered for the OTHER PROCEDURES field or the CONCURRENT PROCEDURES field, the summary will display ***INFORMATION ENTERED*** to the right of the items.

If assistance is needed while interacting with the software, the user should enter one or two question marks (**??**) to receive on-line help.

Example: Enter/Edit Operation Information

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: O  Operation
Information (Enter/Edit)
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264                  PAGE: 1 OF 2
Surgeon: SURSURGEON,ONE
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
-------------------------------------------------------------------------------
Postop Diagnosis Code (ICD9): NOT ENTERED

 1. Surgical Specialty:          ORTHOPEDICS
 2. Principal Operation:         ARTHROSCOPY, LEFT KNEE
 3. CPT Codes (view only):       29873-LT
 4. Other Procedures:
 5. Concurrent Procedure:
 6. PGY of Primary Surgeon:
 7. Surgical Priority:           ELECTIVE
 8. Wound Classification:        CLEAN
 9. ASA Classification:          1-NO DISTURB.
10. Princ. Anesthesia Technique: GENERAL
11. RBC Units Transfused:
12. Major or Minor:              MAJOR
13. Intraop Disseminated Cancer:
-------------------------------------------------------------------------------

Select Operative Information to Edit: 8:9
```

This information cannot be edited.

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
Surgeon: SURSURGEON,ONE
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
-------------------------------------------------------------------------------

Wound Classification: CLEAN// CL
     1   CLEAN
     2   CLEAN/CONTAMINATED
```

```
Choose 1-2: 2  CLEAN/CONTAMINATED
ASA Class: 1-NO DISTURB.// 2    2     2-MILD DISTURB.
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264                  PAGE: 1 OF 2
Surgeon: SURSURGEON,ONE
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
-------------------------------------------------------------------------------
Postop Diagnosis Code (ICD9): NOT ENTERED

 1. Surgical Specialty:          ORTHOPEDICS
 2. Principal Operation:         ARTHROSCOPY, LEFT KNEE
 3. CPT Codes (view only):       29873-LT
 4. Other Procedures:
 5. Concurrent Procedure:
 6. PGY of Primary Surgeon:
 7. Surgical Priority:           ELECTIVE
 8. Wound Classification:        CLEAN/CONTAMINATED
 9. ASA Classification:          2-MILD DISTURB.
10. Princ. Anesthesia Technique: GENERAL
11. RBC Units Transfused:
12. Major or Minor:              MAJOR
13. Intraop Disseminated Cancer:
-------------------------------------------------------------------------------

Select Operative Information to Edit: <Enter>
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264                  PAGE: 2 OF 2
Surgeon: SURSURGEON,ONE
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
-------------------------------------------------------------------------------

1. Patient in Room (PIR):              JUN 07, 2005  07:00
2. Procedure/Surgery Start Time (PST): JUN 07, 2005  07:10
3. Procedure/Surgery Finish (PF):      JUN 07, 2005  08:15
4. Patient Out of Room (POR):          JUN 07, 2005  08:40
5. Anesthesia Start (AS):              JUN 07, 2005  06:30
6. Anesthesia Finish (AF):             JUN 07, 2005  09:00
7. Discharge from PACU (DPACU):

-------------------------------------------------------------------------------

Select Operative Information to Edit:
```

Intraoperative Occurrences (Enter/Edit)
[SRO INTRAOP COMP]

The nurse reviewer uses the *Intraoperative Occurrences (Enter/Edit)* option to enter or change information related to intraoperative occurrences (called complications in earlier versions). Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, enter a question mark (**?**) at the "Enter a New Intraoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter an Intraoperative Occurrence

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: IO  Intraoperative Occurrences
(Enter/Edit)

SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------


There are no Intraoperative Occurrences entered for this case.


Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
  NSQIP Definition (2006):
  The absence of cardiac rhythm or presence of chaotic cardiac rhythm
  that results in loss of consciousness requiring the initiation of any
  component of basic and/or advanced cardiac life support. Patients with
  AICDs that fire but the patient does not lose consciousness should be
  excluded.

  CICSP Definition (2004):
  Indicate if there was any cardiac arrest requiring external or open
  cardiopulmonary resuscitation (CPR) occurring in the operating room,
  ICU, ward, or out-of-hospital after the chest had been completely
  closed and within 30 days of surgery.

Press RETURN to continue: <Enter>

SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: 4:5

SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

Type of Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: <Enter>
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------
Enter/Edit Intraoperative Occurrences

1.  CARDIAC ARREST REQUIRING CPR
     Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:
```

Postoperative Occurrences (Enter/Edit)
[SRO POSTOP COMP]

The nurse reviewer uses the *Postoperative Occurrences (Enter/Edit)* option to enter or change information related to postoperative occurrences (called complications in earlier versions). Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user should enter a question mark (**?**) at the "Enter a New Postoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter a Postoperative Occurrence

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: PO  Postoperative Occurrences
(Enter/Edit)
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: ACUTE RENAL FAILURE
  NSQIP Definition (2006):
  In a patient who did not require dialysis preoperatively, worsening of
  renal dysfunction (increase in serum creatinine to >2.0 and two times
  most recent preoperative creatinine level) and postoperatively
  requiring hemodialysis, peritoneal dialysis, hemofiltration,
  hemodiafiltration or ultrafiltration.

  TIP: If the patient refuses dialysis report as an occurrence because
  he/she did require dialysis.

  CICSP Definition (2004):
  Indicate if the patient developed new renal failure requiring dialysis
  or experienced an exacerbation of preoperative renal failure requiring
  initiation of dialysis (not on dialysis preoperatively) within 30 days
  postoperatively.


Press RETURN to continue: <Enter>
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

1. Occurrence:            ACUTE RENAL FAILURE
2. Occurrence Category:   ACUTE RENAL FAILURE
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: 4
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------


Treatment Instituted: DIALYSIS
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------


1. Occurrence:            ACUTE RENAL FAILURE
2. Occurrence Category:   ACUTE RENAL FAILURE
3. ICD Diagnosis Code:
4. Treatment Instituted:  DIALYSIS
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: <Enter>
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------
Enter/Edit Postoperative Occurrences

1.  ACUTE RENAL FAILURE
     Category: ACUTE RENAL FAILURE

Select a number (1), or type 'NEW' to enter another occurrence:
```

Clinical Information (Enter/Edit)
[SROA CLINICAL INFORMATION]

The *Clinical Information (Enter/Edit)* option is used to enter the clinical information required for a cardiac risk assessment. The software will present one page; at the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance the user to another option.

About the "Select Clinical Information to Edit:" Prompt

At the "Select Clinical Information to Edit:" prompt, the user should enter the item number to edit. The user can then enter an **A** for **ALL** to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data. If assistance is needed while interacting with the software, the user can enter one or two question marks (**??**) to receive on-line help.

Example: Enter Clinical Information

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CLIN  Clinical
Information (Enter/Edit)
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                      PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

 1. Height:                  63 in       13. Prior MI:                    NONE
 2. Weight:                  170 lb      14. Number prior heart surgeries:
 3. Diabetes:                            15. Prior heart surgeries:
 4. COPD:                                16. Peripheral Vascular Disease:
 5. FEV1:                                17. Cerebral Vascular Disease:
 6. Cardiomegaly (X-ray):                18. Angina (use CCS Class):
 7. Pulmonary Rales:                     19. CHF (use NYHA Class):
 8. Current Smoker:                      20. Current Diuretic Use:
 9. Active Endocarditis:                 21. Current Digoxin Use:
10. Resting ST Depression:               22. IV NTG within 48 Hours:
11. Functional Status:                   23. Preop circulatory Device:
12. PCI:                                 24. Hypertension (Y/N):

-------------------------------------------------------------------------------
Select Clinical Information to Edit: A
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

Patient's Height 63 INCHES//: 76
Patient's Weight170 LBS.//: 210
Diabetes: O  ORAL
History of Severe COPD (Y/N): Y  YES
FEV1 : NS
Cardiomegaly on Chest X-Ray (Y/N): Y  YES
Pulmonary Rales (Y/N): Y  YES
Current Smoker: 2  WITHIN 2 WEEKS OF SURGERY
Active Endocarditis (Y/N): N  NO
Resting ST Depression (Y/N): N  NO
Functional Health Status at Evaluation for Surgery: I  INDEPENDENT
PCI: 0  NONE
Prior Myocardial Infarction: 1  LESS THAN OR EQUAL TO 7 DAYS PRIOR TO SURGERY
Number of Prior Heart Surgeries: 1  1
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                      PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

Prior heart surgeries:

0. None                      3. CABG/Valve
1. CABG-only                 4. Other
2. Valve-only                5. CABG/Other

Enter your choice(s) separated by commas  (0-5): // 2
                                          2 - Valve-only
Peripheral Vascular Disease (Y/N): Y  YES
Cerebral Vascular Disease (Y/N): N  NO
Angina (use CCS Functional Class): IV  CLASS IV
Congestive Heart Failure (use NYHA Functional Class): II  SLIGHT LIMITATION
Current Diuretic Use (Y/N): Y  YES
Current Digoxin Use (Y/N): N  NO
IV NTG within 48 Hours Preceding Surgery (Y/N): Y  YES
Preop use of circulatory Device: N  NONE
History of Hypertension (Y/N): Y  YES
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                      PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

 1. Height:                  76 in       13. Prior MI:            < OR = 7 DAYS
 2. Weight:                  210 lb      14. Number prior heart surgeries: 1
 3. Diabetes:                ORAL        15. Prior heart surgeries:  VALVE-ONLY
 4. COPD:                     YES        16. Peripheral Vascular Disease:  YES
 5. FEV1:                     NS         17. Cerebral Vascular Disease:    NO
 6. Cardiomegaly (X-ray):     YES        18. Angina (use CCS Class):       IV
 7. Pulmonary Rales:          YES        19. CHF (use NYHA Class):         II
 8. Current Smoker: WITHIN 2 WEEKS OF S  20. Current Diuretic Use:         YES
 9. Active Endocarditis:      NO         21. Current Digoxin Use:          NO
10. Resting ST Depression:    NO         22. IV NTG within 48 Hours:       YES
11. Functional Status:       INDEPENDENT 23. Preop circulatory Device:     NONE
12. PCI:                          NONE   24. Hypertension (Y/N):          YES

------------------------------------------------------------------------------
Select Clinical Information to Edit:
```

Laboratory Test Results (Enter/Edit)
[SROA LAB-CARDIAC]

The *Laboratory Test Results (Edit/Edit)* option is used to enter or edit preoperative laboratory test results for an individual cardiac risk assessment. The option is divided into the two features listed below. The first feature allows the user to merge (also called "capture" or "load") lab information into the risk assessment from the VistA software. The second feature provides a two-page summary of the lab profile and allows direct editing of the information.

1. Capture Laboratory Information
2. Enter, Edit, or Review Laboratory Test Results

To "capture" preoperative lab data, the user must provide both the date and time the operation began. If this information has already been entered, the system will not prompt for it again.

If assistance is needed while interacting with the software, entering one or two question marks (**??**) allows the user to access the on-line help.

About the "Select Laboratory Information to Edit:" Prompt

At this prompt the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter Laboratory Test Results

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: LAB  Laboratory
Test Results (Enter/Edit)


SURPATIENT,NINETEEN (000-28-7354)        Case #60183                      PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

Enter/Edit Laboratory Test Results

1. Capture Laboratory Information
2. Enter, Edit, or Review Laboratory Test Results

Select Number: 1

This selection loads the most recent cardiac lab data for tests performed
preoperatively.

Do you want to automatically load cardiac lab data ?  YES// <Enter>

..Searching lab record for latest test data....

Press <RET> to continue  <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                        PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

Enter/Edit Laboratory Test Results

1. Capture Laboratory Information
2. Enter, Edit, or Review Laboratory Test Results

Select Number: 2
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                        PAGE: 1
PREOPERATIVE LABORATORY RESULTS
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

 1. HDL:                    NS
 2. LDL:                   168    (JAN 2004)
 3. Total Cholesterol:     321    (JAN 2004)
 4. Serum Triglyceride:    >70    (JAN 2004)
 5. Serum Potassium:        NS
 6. Serum Bilirubin:        NS
 7. Serum Creatinine:       NS
 8. Serum Albumin:          NS
 9. Hemoglobin:             NS
10. Hemoglobin A1c:         NS

-------------------------------------------------------------------------------

Select Laboratory Information to Edit: 1
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                        PAGE: 1
PREOPERATIVE LABORATORY RESULTS
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

HDL (mg/dl): NS// 177
HDL, Date: JAN, 2005  (JAN 2005)
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                        PAGE: 1
PREOPERATIVE LABORATORY RESULTS
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

 1. HDL:                   177    (JAN 2005)
 2. LDL:                   168    (JAN 2004)
 3. Total Cholesterol:     321    (JAN 2004)
 4. Serum Triglyceride:    >70    (JAN 2004)
 5. Serum Potassium:        NS
 6. Serum Bilirubin:        NS
 7. Serum Creatinine:       NS
 8. Serum Albumin:          NS
 9. Hemoglobin:             NS
10. Hemoglobin A1c:         NS

-------------------------------------------------------------------------------

Select Laboratory Information to Edit:
```

Enter Cardiac Catheterization & Angiographic Data
[SROA CATHETERIZATION]

The *Enter Cardiac Catheterization & Angiographic Data* option is used to enter or edit cardiac catheterization and angiographic information for a cardiac risk assessment. The software will present one page. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance the user to another option.

About the "Select Cardiac Catheterization and Angiographic Information to Edit:" Prompt

At this prompt the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items.

After the information has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter Cardiac Catheterization & Angiographic Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CATH  Enter Cardiac
Catheterization & Angiographic Data

SURPATIENT,NINETEEN (000-28-7354)        Case #60183                   PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
1. Procedure:
2. LVEDP:
3. Aortic Systolic Pressure:

For patients having right heart cath
4. PA Systolic Pressure:
5. PAW Mean Pressure:

6. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo):

7. Mitral Regurgitation:
8. Aortic Stenosis:

------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: A

SURPATIENT,NINETEEN (000-28-7354)        Case #60183                   PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

Procedure Type: NS  NO STUDY/UNKNOWN
Do you want to automatically enter 'NS' for NO STUDY for all other fields within
  this option ? YES// <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                    PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

1. Procedure:                NS
2. LVEDP:                    NS
3. Aortic Systolic Pressure:  NS

For patients having right heart cath
4. PA Systolic Pressure:      NS
5. PAW Mean Pressure:         NS

6. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo): NO LV STUDY

7. Mitral Regurgitation:      NS
8. Aortic Stenosis:           NS

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: A
```

```
Procedure Type: NS/UNKNOWN// CATH CATH
You have changed the answer from "NS".
Do you want to clear 'NS' from all other fields within this option ? NO// N  NO

Left Ventricular End-Diastolic Pressure: NS// 56
Aortic Systolic Pressure: NS// 120
PA Systolic Pressure: NS//30
PAW Mean Pressure: NS//15
LV Contraction Grade: NS//?
Enter the grade that best describes left ventricular function.
     Screen prevents selection of code III.
     Choose from:
       I        > EQUAL 0.55 NORMAL
       II       0.45-0.54 MILD DYSFUNC.
       IIIa     0.40-0.44 MOD. DYSFUNC. A
       IIIb     0.35-0.39 MOD. DYSFUNC. B
       IV       0.25-0.34 SEVERE DYSFUNC.
       V        <0.25 VERY SEVERE DYSFUNC.
       NS       NO STUDY
LV Contraction Grade: NS//IIIa  0.40-0.44 MOD. DYSFUNC. A
Mitral Regurgitation: NS//?
     Enter the code describing presence/severity of mitral regurgitation.
     Choose from:
       0        NONE
       1        MILD
       2        MODERATE
       3        SEVERE
       NS       NO STUDY
Mitral Regurgitation: NS//2  MODERATE
Aortic Stenosis: NS//1  MILD
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                    PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
1. Procedure:                Cath
2. LVEDP:                     56 mm Hg
3. Aortic Systolic Pressure: 120 mm Hg

For patients having right heart cath
4. PA Systolic Pressure:      30 mm Hg
5. PAW Mean Pressure:         15 mm Hg
6. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo): IIIa 0.40-0.44 MODERATE DYSFUNCTION A

7. Mitral Regurgitation:      MODERATE
8. Aortic Stenosis:           MILD

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                      PAGE: 2 of 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

----- Native Coronaries -----
1. Left main stenosis:          NS
2. LAD Stenosis:                NS
3. Right coronary stenosis:     NS
4. Circumflex Stenosis:         NS

If a Re-do, indicate stenosis in graft to:
5. LAD:                         NS
6. Right coronary:              NS
7. Circumflex:                  NS

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: 3
Right Coronary Artery Stenosis: NS// ?
     Enter the percent (0-100) stenosis.
Right Coronary Artery Stenosis: NS// 30
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                      PAGE: 2 of 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

----- Native Coronaries -----
1. Left main stenosis:          NS
2. LAD Stenosis:                NS
3. Right coronary stenosis:     30
4. Circumflex Stenosis:         NS

If a Re-do, indicate stenosis in graft to:
5. LAD:                         NS
6. Right coronary:              NS
7. Circumflex:                  NS

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit:
```

(This page included for two-sided copying.)

Cardiac Procedures Operative Data (Enter/Edit)
[SROA CARDIAC PROCEDURES]

The *Cardiac Procedures Operative Data (Enter/Edit)* option is used to enter or edit information related to cardiac procedures requiring cardiopulmonary bypass (CPB). The software will present two pages. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance the user to another option.

About the "Select Operative Information to Edit:" prompt

At this prompt, the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items. You can also use number-letter combinations, such as **11B**, to update a field within a group, such as VSD Repair.

Each prompt at the category level allows for an entry of **YES** or **NO**. If **NO** is entered, each item under that category will automatically be answered **NO**. On the other hand, responding **YES** at the category level allows the user to respond individually to each item under the main category.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter Cardiac Procedures Operative Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CARD  Cardiac Pr
ocedures Operative Data (Enter/Edit)

SURPATIENT,NINETEEN (000-28-7354)   Case #60183                    PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:               11. Bridge to transplant/Device:
 1. Number with vein:                  12. TMR:
 2. Number with IMA:                   13. Maze procedure:
 3. Number with Radial Artery:         14. ASD repair:
 4. Number with Other Artery:          15. VSD repair:
 5. Number with Other Conduit:         16. Myectomy for IHSS:
                                       17. Myxoma resection:
 6. Aortic Valve Replacement:          18. Other tumor resection:
 7. Mitral Valve Replacement:          19. Cardiac transplant:
 8. Tricuspid Valve Replacement:       20. Great Vessel Repair:
 9. Valve Repair:                      21. Endovascular Repair:
10. LV Aneurysmectomy:                 22. Other cardiac procedures:

-------------------------------------------------------------------------------

Select Operative Information to Edit: A
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

CABG Distal Anastomoses with Vein: 1
CABG Distal Anastomoses with IMA: 1
Number with Radial Artery: 0
Number with Other Artery: 1
CABG Distal Anastomoses with Other Conduit: 1
Aortic Valve Replacement (Y/N): Y  YES
Mitral Valve Replacement (Y/N): N  NO
Tricuspid Valve Replacement (Y/N): N  NO
Valve Repair: ??
        CICSP Definition (2006):
        Indicate if the patient has had any reparative procedure to a native
        valve, either with or without placing the patient on cardiopulmonary
        bypass. Valve repair is defined as a procedure performed on the native
        valve to relieve stenosis and/or correct regurgitation (annuloplasty,
        commissurotomy, etc.); the native valve remains in place. Indicate the
        one appropriate response.

     Choose from:
       1        AORTIC
       2        MITRAL
       3        TRICUSPID
       4        OTHER/COMBINATION
       5        NONE
Valve Repair: 1  AORTIC
LV Aneurysmectomy (Y/N): N  NO
Device for bridge to cardiac transplant / Destination therapy:??
        CICSP Definition (2006):
        Indicate if patient received a mechanical support device
        (excluding IABP) as a bridge to cardiac transplant during the same
        admission as the transplant procedure; or patient received the device
        as destination therapy (does not intend to have a cardiac transplant),
        either with or without placing the patient on cardiopulmonary bypass.

     Choose from:
       Y        YES
       N        NO
Device for bridge to cardiac transplant / Destination therapy: N  NO
Transmyocardial Laser Revascularization: N  NO
Maze Procedure: N  NO MAZE PERFORMED
ASD Repair (Y/N): N  NO
VSD Repair (Y/N): N  NO
Myectomy for IHSS (Y/N): N  NO
Myxoma Resection (Y/N): N  NO
Other Tumor Resection (Y/N): N  NO
Cardiac Transplant (Y/N): N  NO
Great Vessel Repair (Y/N): N  NO
Endovascular Repair of Descending Thoracic Aorta: N  NO
Other Cardiac Procedures (Y/N): N  NO
```

```
SURPATIENT,NINETEEN (000-28-7354)       Case #60183                PAGE: 1 of 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:                11. Bridge to transplant/Device:   NO
 1. Number with vein:             1     12. TMR:                           NO
 2. Number with IMA:              1     13. Maze procedure: NO MAZE PERFORMED
 3. Number with Radial Artery:    0     14. ASD repair:                    NO
 4. Number with Other Artery:     1     15. VSD repair:                    NO
 5. Number with Other Conduit:    1     16. Myectomy for IHSS:             NO
                                        17. Myxoma resection:              NO
 6. Aortic Valve Replacement:     YES   18. Other tumor resection:         NO
 7. Mitral Valve Replacement:     NO    19. Cardiac transplant:            NO
 8. Tricuspid Valve Replacement:  NO    20. Great Vessel Repair:           NO
 9. Valve Repair:              AORTIC   21. Endovascular Repair:           NO
10. LV Aneurysmectomy:            NO    22. Other cardiac procedures:      NO

-------------------------------------------------------------------------------
Select Operative Information to Edit: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)      Case #60183                 PAGE: 2 of 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
Indicate other cardiac procedures only if done with cardiopulmonary bypass
-------------------------------------------------------------------------------

 1. Foreign Body Removal:
 2. Pericardiectomy:

Other Operative Data details:
-----------------------------
 3. Total CPB Time:
 4. Total Ischemic Time:
 5. Incision Type:
 6. Convert Off Pump to CPB:  N/A (began on-pump/ stayed on-pump)
-------------------------------------------------------------------------------

Select Operative Information to Edit:
```

Outcome Information (Enter/Edit)
[SROA CARDIAC-OUTCOMES]

This option is used to enter or edit outcome information for cardiac procedures.

Example: Enter Outcome Information

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: OUT  Outcome Inf
ormation (Enter/Edit)

SURPATIENT,TWENTY (000-45-4886)     Case #238                          PAGE: 1
OUTCOMES INFORMATION
FEB 10,2004   CABG
------------------------------------------------------------------------------

0. Operative Death:                NO

Perioperative (30 day) Occurrences:

1. Perioperative MI:               NO      8. Repeat cardiac surg procedure:  NO
2. Endocarditis:                   NO      9. Tracheostomy:                   YES
3. Renal failure require dialysis: NO     10. Repeat ventilator w/in 30 days: YES
4. Mediastinitis:                  YES    11. Stroke:                        NO
5. Cardiac arrest requiring CPR:   YES    12. Coma >= 24 hr:                 NO
6. Reoperation for bleeding:       NO     13. New Mech Circ Support:         YES
7. On ventilator >= 48 hr:         NO

------------------------------------------------------------------------------

Select Outcomes Information to Edit: 8
Repeat Cardiac Surgical Procedure (Y/N): NO// Y  YES
Cardiopulmonary Bypass Status: ?

Enter NONE, ON BYPASS, or OFF BYPASS.
0        None
1        On-bypass
2        Off-bypass


Cardiopulmonary Bypass Status: 1  On-bypass
```

```
SURPATIENT,TWENTY (000-45-4886)     Case #238                          PAGE: 1
OUTCOMES INFORMATION
FEB 10,2004   CABG
------------------------------------------------------------------------------

0. Operative Death:                NO

Perioperative (30 day) Occurrences:

1. Perioperative MI:               NO      8. Repeat cardiac surg procedure:  YES
2. Endocarditis:                   NO      9. Tracheostomy:                   YES
3. Renal failure require dialysis : NO    10. Repeat ventilator w/in 30 days: YES
4. Mediastinitis:                  YES    11. Stroke:                        NO
5. Cardiac arrest requiring CPR:   YES    12. Coma >= 24 hr:                 NO
6. Reoperation for bleeding:       NO     13. New Mech Circ Support:         YES
7. On ventilator >= 48 hr:         NO

------------------------------------------------------------------------------

Select Outcomes Information to Edit:
```

Intraoperative Occurrences (Enter/Edit)
[SRO INTRAOP COMP]

The nurse reviewer uses the *Intraoperative Occurrences (Enter/Edit)* option to enter or change information related to intraoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user can enter a question mark (**?**) at the "Enter a New Intraoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another opportunity to enter or edit data.

Example: Enter an Intraoperative Occurrence

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: IO  Intraoperative Occurrences
(Enter/Edit)

SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

There are no Intraoperative Occurrences entered for this case.


Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
  NSQIP Definition (2006):
  The absence of cardiac rhythm or presence of chaotic cardiac rhythm
  that results in loss of consciousness requiring the initiation of any
  component of basic and/or advanced cardiac life support. Patients with
  AICDs that fire but the patient does not lose consciousness should be
  excluded.

  CICSP Definition (2004):
  Indicate if there was any cardiac arrest requiring external or open
  cardiopulmonary resuscitation (CPR) occurring in the operating room,
  ICU, ward, or out-of-hospital after the chest had been completely
  closed and within 30 days of surgery.

Press RETURN to continue: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

1. Occurrence:          CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: 2:5
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

Occurrence Category: CARDIAC ARREST REQUIRING CPR
         // <Enter>
ICD Diagnosis Code: 102.8  102.8        LATENT YAWS
         ...OK? YES// <Enter>   (YES)
Type of Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:    102.8
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
Enter/Edit Intraoperative Occurrences

1.   CARDIAC ARREST REQUIRING CPR
     Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:
```

Postoperative Occurrences (Enter/Edit)
[SRO POSTOP COMP]

The nurse reviewer uses the *Postoperative Occurrences (Enter/Edit)* option to enter or change information related to postoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user can enter a question mark (**?**) at the "Enter a New Postoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another opportunity to enter or edit data.

Example: Enter a Postoperative Occurrence

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: PO  Postoperative Occurrences
(Enter/Edit)

SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: CARDIAC ARREST REQUIRING CPR
  NSQIP Definition (2006):
  The absence of cardiac rhythm or presence of chaotic cardiac rhythm
  that results in loss of consciousness requiring the initiation of any
  component of basic and/or advanced cardiac life support. Patients with
  AICDs that fire but the patient does not lose consciousness should be
  excluded.

  CICSP Definition (2004):
  Indicate if there was any cardiac arrest requiring external or open
  cardiopulmonary resuscitation (CPR) occurring in the operating room,
  ICU, ward, or out-of-hospital after the chest had been completely
  closed and within 30 days of surgery.

Press RETURN to continue: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------


1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: 4:6
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
Date/Time the Occurrence was Noted: 6/19/05  (JUN 19, 2005)
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Date Noted:            06/19/05
7. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
Enter/Edit Intraoperative Occurrences

1.   CARDIAC ARREST REQUIRING CPR
     Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:
```

Print a Surgery Risk Assessment

[SROA PRINT ASSESSMENT]

The *Print a Surgery Risk Assessment* option prints an entire Surgery Risk Assessment Report for an individual patient. This report can be displayed temporarily on a screen. As the report fills the screen, the user will be prompted to press the **<Enter>** key to go to the next page. A permanent record can be made by copying the report to a printer. When using a printer, the report is formatted slightly differently from the way it displays on the terminal.

Example 1: Print Surgery Risk Assessment for a Non-Cardiac Case

```
Select Surgery Risk Assessment Menu Option: P  Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO//  <Enter>


Select Patient: SURPATIENT,FORTY         05-07-23     000777777     NO     NSC VET
ERAN

SURPATIENT,FORTY  000-77-7777

1. 02-10-04   * CABG (INCOMPLETE)

2. 01-09-06   APPENDECTOMY (COMPLETED)


Select Surgical Case: 2

Print the Completed Assessment on which Device: [Select Print Device]
```

----------*printout follows*----------

```
VA NON-CARDIAC RISK ASSESSMENT            Assessment: 236          PAGE 1
FOR SURPATIENT,FORTY  000-77-7777 (COMPLETED)
================================================================================

Medical Center: ALBANY
Age:            81                    Operation Date:    JAN 09, 2004
Sex:            MALE                  Ethnicity: NOT HISPANIC OR LATINO
                                      Race:      AMERICAN INDIAN OR ALASKA
                                                 NATIVE, NATIVE HAWAIIAN OR
                                                 OTHER PACIFIC ISLANDER, WHITE
Transfer Status: NOT TRANSFERRED
Observation Admission Date:                  NA
Observation Discharge Date:                  NA
Observation Treating Specialty:              NA
Hospital Admission Date:                     JAN 7,2006   11:15
Hospital Discharge Date:                     JAN 12,2006  10:30
Admitted/Transferred to Surgical Service:    JAN 7,2006   11:15
Discharged/Transferred to Chronic Care:      JAN 12,2006  10:30
In/Out-Patient Status:                       INPATIENT

--------------------------------------------------------------------------------

                          PREOPERATIVE INFORMATION

GENERAL:                      YES      HEPATOBILIARY:                YES
Height:              176 CENTIMETERS   Ascites:                      YES
Weight:                 89 KILOGRAMS
Diabetes Mellitus:            INSULIN  GASTROINTESTINAL:             YES
Current Smoker W/I 1 Year:    YES      Esophageal Varices:           YES
Pack/Years:                   0
ETOH > 2 Drinks/Day:          NO       CARDIAC:                      NO
Dyspnea:                      NO       CHF Within 1 Month:           NO
DNR Status:                   NO       MI Within 6 Months:           NO
Functional Status:        INDEPENDENT  Previous PTCA:                 NO
                                       Previous Cardiac Surgery:     NO
PULMONARY:                    YES      Angina Within 1 Month:        NO
Ventilator Dependent:         NS       Hypertension Requiring Meds:  NO
History of Severe COPD:       NO
Current Pneumonia:            NO       VASCULAR:                     YES
                                       Revascularization/Amputation: NO
                                       Rest Pain/Gangrene:           YES

RENAL:                        YES      NUTRITIONAL/IMMUNE/OTHER:     YES
Acute Renal Failure:          NO       Disseminated Cancer:          NO
Currently on Dialysis:        NO       Open Wound:                   NO
                                       Steroid Use for Chronic Cond.: NO
CENTRAL NERVOUS SYSTEM:       YES      Weight Loss > 10%:            NO
Impaired Sensorium:           NO       Bleeding Disorders:           NO
Coma:                         NO       Transfusion > 4 RBC Units:    NO
Hemiplegia:                   NO       Chemotherapy W/I 30 Days:     NO
History of TIAs:              NO       Radiotherapy W/I 90 Days:     NO
CVA/Stroke w. Neuro Deficit:  YES      Preoperative Sepsis:          NONE
CVA/Stroke w/o Neuro Deficit: NO       Pregnancy:          NOT APPLICABLE
Tumor Involving CNS:          NO
Paraplegia:                   NO
Quadriplegia:                 NO


                      OPERATION DATE/TIMES INFORMATION

              Patient in Room (PIR): JAN 9,2006  07:25
   Procedure/Surgery Start Time (PST): JAN 9,2006  07:25
        Procedure/Surgery Finish (PF): JAN 9,2006  08:00
            Patient Out of Room (POR): JAN 9,2006  08:10
                Anesthesia Start (AS): JAN 9,2006  07:15
               Anesthesia Finish (AF): JAN 9,2006  08:08
         Discharge from PACU (DPACU): JAN 9,2006  09:15
```

```
VA NON-CARDIAC RISK ASSESSMENT            Assessment: 236          PAGE 2
FOR SURPATIENT,FORTY  000-77-7777 (COMPLETED)
================================================================================
                           OPERATIVE INFORMATION

                  Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

                 Principal Operation: APPENDECTOMY

                 Procedure CPT Codes: 44950


                Concurrent Procedure:
                            CPT Code:
              PGY of Primary Surgeon: 0
                Emergency Case (Y/N): NO
                      Major or Minor: MAJOR
                Wound Classification: CONTAMINATED
                  ASA Classification: 3-SEVERE DISTURB.
                       Airway Trauma: NONE
                    Mallampati Scale: CLASS 3
      Principal Anesthesia Technique: GENERAL
                       Airway Index: NOT ENTERED
              RBC Units Transfused: 0
         Intraop Disseminated Cancer:


                   PREOPERATIVE LABORATORY TEST RESULTS

                           Anion Gap: 12         (JAN 7,2006)
                       Serum Sodium: 144.6       (JAN 7,2006)
                    Serum Creatinine: .9         (JAN 7,2006)
                                 BUN: 18         (JAN 7,2006)
                       Serum Albumin: 3.5        (JAN 7,2006)
                     Total Bilirubin: .9         (JAN 7,2006)
                                SGOT: 46         (JAN 7,2006)
                Alkaline Phosphatase: 34         (JAN 7,2006)
                   White Blood Count: 15.9       (JAN 7,2006)
                          Hematocrit: 43.4       (JAN 7,2006)
                      Platelet Count: 356        (JAN 7,2006)
                                 PTT: 25.9       (JAN 7,2006)
                                  PT: 12.1       (JAN 7,2006)
                                 INR: 1.54       (JAN 7,2006)


                     POSTOPERATIVE LABORATORY RESULTS

                              * Highest Value
                             ** Lowest Value

                          * Anion Gap: 11         (JAN 7,2006)
                       * Serum Sodium: 148        (JAN 12,2006)
                      ** Serum Sodium: 144.2      (FEB 2,2006)
                          * Potassium: 4.5        (JAN 12,2006)
                         ** Potassium: 4.5        (JAN 12,2006)
                    * Serum Creatinine: 1.4        (FEB 2,2006)
                                * CPK: 88         (JAN 12,2006)
                           * CPK-MB Band: <1       (JAN 12,2006)
                     * Total Bilirubin: 1.3        (JAN 12,2006)
                    * White Blood Count: 12.2      (JAN 12,2006)
                          ** Hematocrit: 42.9      (JAN 12,2006)
                           * Troponin I: 1.42      (JAN 12,2006)
                           * Troponin T: NS
```

```
VA NON-CARDIAC RISK ASSESSMENT            Assessment: 236          PAGE 3
FOR SURPATIENT,FORTY  000-77-7777 (COMPLETED)
================================================================================

                           OUTCOME INFORMATION

  Postoperative Diagnosis Code (ICD9): 540.1  ABSCESS OF APPENDIX
Length of Postoperative Hospital Stay: 3 DAYS
                        Date of Death:
          Return to OR Within 30 Days: NO


                     PERIOPERATIVE OCCURRENCE INFORMATION

WOUND OCCURRENCES:               YES     CNS OCCURRENCES:                YES
Superficial Incisional SSI:      NO      Stroke/CVA:                     NO
Deep Incisional SSI:             NO      Coma > 24 Hours:                NO
Wound Disruption:             01/10/06   Peripheral Nerve Injury:     01/10/06
* 427.31 ATRIAL FIBRILLATI    01/10/06

URINARY TRACT OCCURRENCES:       YES     CARDIAC OCCURRENCES:            YES
Renal Insufficiency:             NO      Arrest Requiring CPR:           NO
Acute Renal Failure:             NO      Myocardial Infarction:       01/09/06
Urinary Tract Infection:      01/11/06

RESPIRATORY OCCURRENCES:         YES     OTHER OCCURRENCES:              YES
Pneumonia:                       NO      Bleeding/Transfusions:          NO
Unplanned Intubation:            NO      Graft/Prosthesis/Flap Failure:  NO
Pulmonary Embolism:              NO      DVT/Thrombophlebitis:           NO
On Ventilator > 48 Hours:        NO      Systemic Sepsis: SEPTIC SHOCK 01/11/06
* 477.0 RHINITIS DUE TO P     01/12/06   Organ/Space SSI:             01/11/06
* indicates Other (ICD9)
```

Example 2: Print Surgery Risk Assessment for a Cardiac Case

```
Select Surgery Risk Assessment Menu Option: P  Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO//  <Enter>


Select Patient: R9922  SURPATIENT,NINE         12-19-51     000345555     NO     SC
 VETERAN

SURPATIENT,NINE  000-34-5555

1. 07-01-06   * CABG X3 (1A,2V), ARTERIAL GRAFTING (TRANSMITTED)

2. 03-27-05   INGUINAL HERNIA (TRANSMITTED)

3. 07-03-04   PULMONARY LOBECTOMY (TRANSMITTED)


Select Surgical Case: Select Surgical Case: 1

Print the Completed Assessment on which Device: [Select Print Device]
```

----------*printout follows*----------

```
VA CONTINUOUS IMPROVEMENT IN CARDIAC SURGERY PROGRAM (CICSP/CICSP-X)

================================================================================
I. IDENTIFYING DATA
Patient: SURPATIENT,NINE  000-34-5555      Case #: 238         Fac./Div. #: 500
Surgery Date: 07/01/06   Address: Anyplace Way
Phone: NS/Unknown        Zip Code: 33445-1234        Date of Birth: 12/19/51
================================================================================
II. CLINICAL DATA
Gender:                   MALE          PCI:                >72 hrs - 7 days
Age:                      55            Prior MI:            > 7 DAYS OF SURG
Height:                   72 in         # of prior heart surgeries:        NONE
Weight:                   120 kg        Prior heart surgeries:
Diabetes:                 DIET          Peripheral Vascular Disease:       NO
COPD:                     NO            Cerebral Vascular Disease:         NO
FEV1:                     NS            Angina (use CCS Class):            III
Cardiomegaly (X-ray):     YES           CHF (use NYHA Class):              I
Pulmonary Rales:          NO            Current Diuretic Use:              NO
Current Smoker: >3 MONTHS PRIOR TO SUR  Current Digoxin Use:               NO
Active Endocarditis:      NO            IV NTG 48 Hours Preceding Surgery: NO
Resting ST Depression:    YES           Preop circulatory Device:         VAD
Functional Status:  PARTIAL DEPENDENT   Hypertension:                      NO

III. DETAILED LABORATORY INFO - PREOPERATIVE VALUES
Creatinine:    1.1 mg/dl (06/28/06)      T. Bilirubin:     .9 mg/dl (06/28/06)
Hemoglobin:   15.6 mg/dl (06/28/06)      T. Cholesterol:  230 mg/dl (06/28/06)
Albumin:       4.4 g/dl  (06/28/06)      HDL:              90 mg/dl (06/28/06)
Triglyceride:   77 mg/dl (06/28/06)      LDL:             125 mg/dl (06/28/06)
Potassium:     4.6 mg/L  (06/28/06)      Hemoglobin A1c:  205 mg/dl (06/28/06)

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA
Cardiac Catheterization Date: 06/28/06
Procedure:                 NS            Native Coronaries:
LVEDP:                     NS            Left Main Stenosis:            NS
Aortic Systolic Pressure:  NS            LAD Stenosis:                  NS
                                         Right Coronary Stenosis:       NS
For patients having right heart cath:    Circumflex Stenosis:           NS
PA Systolic Pressure:      NS
PAW Mean Pressure:         NS            If a Re-do, indicate stenosis
                                             in graft to:
                                         LAD:                           NS
                                         Right coronary (include PDA):  NS
                                         Circumflex:                    NS
--------------------------------------------------------------------------------
LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):
       Grade     Ejection Fraction Range           Definition
        NO LV STUDY
--------------------------------------------------------------------------------
Mitral Regurgitation:     NS
Aortic stenosis:          NS

V. OPERATIVE RISK SUMMARY DATA          (Operation Began: JUL 01, 2006@10:10)
     Physician's Preoperative           (Operation Ended: 07/01/06 12:20)
       Estimate of Operative Mortality: NS               (JUN 28, 2006@15:30)
     ASA Classification:           3-SEVERE DISTURB.
     Surgical Priority:            ELECTIVE              (JUN 28, 2006@15:31)
     Principal CPT Code:           33517
     Other Procedures CPT Codes:  NONE; 33510; NONE
     Preoperative Risk Factors:
```

```
SURPATIENT,NINE  000-34-5555
================================================================================
 VI. OPERATIVE DATA
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:                Bridge to transplant/Device:       NO
  Number with Vein:              2      TMR:                               NO
  Number with IMA:               2      Maze procedure:     NO MAZE PERFORMED
  Number with Radial Artery:     0      ASD repair:                        NO
  Number with Other Artery:      0      VSD repair:                        NO
  Number with Other Conduit:     0      Myectomy for IHSS:                 NO
Aortic Valve Replacement:        NO     Myxoma resection:                  NO
Mitral Valve Replacement:        NO     Other tumor resection:             NO
Tricuspid Valve Replacement:     NO     Cardiac transplant:                NO
Valve Repair:                    NONE   Great Vessel Repair:               NO
LV Aneurysmectomy:               NO     Endovascular Repair:               NO
                                        Other Cardiac procedure(s):       YES
* Other Cardiac procedures (Specify): OTHER CT PROCEDURE #1, OTHER CT PROCEDURE #2,
OTHER CT PROC

Indicate other cardiac procedures only if done with cardiopulmonary bypass
Foreign body removal:            YES
Pericardiectomy:                 YES

Other Operative Data details
Total CPB Time:     85 min               Total Ischemic Time: 60 min
Incision Type:           FULL STERNOTOMY
Conversion Off Pump to CPB: N/A (began on-pump/ stayed on-pump)

VII. OUTCOMES
Operative Death:  NO                      Date of Death:

Perioperative (30 day) Occurrences:
  Perioperative MI:                NO    Repeat cardiac Surg procedure:  YES
  Endocarditis:                    NO    Trachestomy:                    YES
  Renal Failure Requiring Dialysis: NO   Ventilator supp within 30 days: YES
  Mediastinitis:                   YES   Stroke/CVA:                     NO
  Cardiac Arrest Requiring CPR:    YES   Coma > or = 24 Hours:           NO
  Reoperation for Bleeding:        NO    New Mech Circulatory Support:   YES
  On ventilator > or = 48 hr:      NO

VIII. RESOURCE DATA
Hospital Admission Date:                      06/30/06 06:05
Hospital Discharge Date:                      07/10/06 08:50
Time Patient In  OR:                          07/10/06 10:00
Time Patient Out OR:                          07/10/06 12:30
Date and Time Patient Extubated:              07/10/06 13:13
Date and Time Patient Discharged from ICU:    07/10/06 08:00
Patient is Homeless:                          NS
Cardiac Surg Performed at Non-VA Facility:    UNKNOWN
Resource Data Comments: Indicate other cardiac procedures only if done
     with cardiopulmonary bypass
================================================================================
IX. SOCIOECONOMIC, ETHNICITY, AND RACE
 Employment Status Preoperatively:     SELF EMPLOYED
 Ethnicity:                            NOT HISPANIC OR LATINO
 Race Category(ies):                   AMERICAN INDIAN OR ALASKA NATIVE,
                                       NATIVE HAWAIIAN OR OTHER PACIFIC
                                       ISLANDER, WHITE

X. DETAILED DISCHARGE INFORMATION
   Discharge ICD-9 Codes: 414.01  V70.7  433.10  285.1  412.  307.9  427.31

Type of Disposition: TRANSFER
Place of Disposition: HOME-BASED PRIMARY CARE (HBPC)
Primary care or referral VAMC identification code: 526
Follow-up VAMC identification code: 526

 *** End of report for SURPATIENT,NINE  000-34-5555 assessment #238 ***
```

(This page included for two-sided copying.)

List of Surgery Risk Assessments

[SROA ASSESSMENT LIST]

The *List of Surgery Risk Assessments* option is used to print lists of assessments within a date range. Lists of assessments in different phases of completion (for example, incomplete, completed, or transmitted) or a list of all surgical cases entered in the Surgery Risk Assessment software can be printed. The user can also request that the list be sorted by surgical service. The software will prompt for a beginning date and an ending date. Examples 1-8 illustrate printing assessments in each of the following formats.

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information

Example 1: List of Incomplete Assessments

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information

Select the Number of the Report Desired: 1

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>


This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
----------------------------------------------------------printout  follows----------------------------------------------------
```

```
                                        INCOMPLETE RISK ASSESSMENTS                                          PAGE 1
                                              MAYBERRY, NC
                                            SURGERY SERVICE                          DATE REVIEWED:
                                      FROM: JAN 1,2006  TO: JUN 30,2006              REVIEWED BY:

ASSESSMENT #        PATIENT                                   OPERATIVE PROCEDURE(S)              ANESTHESIA TECHNIQUE
OPERATION DATE                        SURGEON
================================================================================================================================

** SURGICAL SPECIALTY: CARDIAC SURGERY **

28519               SURPATIENT,NINE 000-34-5555               * CABG X3 (2V,1A)                   GENERAL
JAN 05, 2006                          SURSURGEON,ONE
                                                              CPT Codes: 33736

--------------------------------------------------------------------------------------------------------------------------------

** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **

63063               SURPATIENT,ONE    000-44-7629             INGUINAL HERNIA                     SPINAL
JUN 09, 2006                          SURSURGEON,TWO
                                                              CPT Codes: 49521


--------------------------------------------------------------------------------------------------------------------------------

** SURGICAL SPECIALTY: NEUROSURGERY **

63154               SURPATIENT,EIGHT 000-37-0555              CRANIOTOMY                          NOT ENTERED
JUN 24, 2006                          SURSURGEON,FOUR
                                                              CPT Codes: NOT ENTERED

--------------------------------------------------------------------------------------------------------------------------------
```

Example 2: List of Completed Assessments

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information

Select the Number of the Report Desired: 2

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>


This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

COMPLETED RISK ASSESSMENTS PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

ASSESSMENT # / OPERATION DATE	PATIENT / OPERATIVE PROCEDURE	DATE COMPLETED	ANESTHESIA TECHNIQUE
** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **			
92 FEB 23, 2006	SURPATIENT,SIXTY 000-56-7821 CHOLEDOCHOTOMY CPT Code: 47420	FEB 28, 2006	GENERAL
63045 MAR 01, 2006	SURPATIENT,FORTYONE 000-43-2109 INGUINAL HERNIA CPT Code: 49521	MAR 29, 2006	GENERAL
** SURGICAL SPECIALTY: OPHTHALMOLOGY **			
1898 APR 28, 2006	SURPATIENT,FORTYONE 000-43-2109 INTRAOCCULAR LENS	MAY 28, 2006 CPT Codes: NOT ENTERED	GENERAL

Example 3: List of Transmitted Assessments

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information

Select the Number of the Report Desired: 3

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// N

Print the Report for which Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)  GENERAL(OR
WHEN NOT DEFINED BELOW)        50


This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

TRANSMITTED RISK ASSESSMENTS PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

ASSESSMENT # / OPERATION DATE	PATIENT / PRINCIPAL OPERATIVE PROCEDURE	TRANSMISSION DATE	ANESTHESIA TECHNIQUE
** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **			
63076 JAN 08, 2006	SURPATIENT,FOURTEEN 000-45-7212 INGUINAL HERNIA CPT Codes: 49521	FEB 12, 2006	GENERAL
63077 FEB 08, 2006	SURPATIENT,FIVE 000-58-7963 INGUINAL HERNIA, OTHER PROC1 CPT Codes: NOT ENTERED	FEB 30, 2006	GENERAL
63103 MAR 27, 2006	SURPATIENT,NINE 000-34-5555 INGUINAL HERNIA CPT Codes: 49521	APR 09, 2006	GENERAL
63171 MAY 17, 2006	SURPATIENT,FIFTYTWO 000-99-8888 CHOLECYSTECTOMY CPT Codes: 47600	JUN 05, 2006	GENERAL

Example 4: List of Non-Assessed Major Surgical Cases

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information

Select the Number of the Report Desired: 4

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// N

Print the Report for which Surgical Specialty: GENERAL(OR WHEN NOT
DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)        50


This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

```
                    NON-ASSESSED MAJOR SURGICAL CASES BY SURGICAL SPECIALTY                    PAGE 1
                                                MAYBERRY, NC
                                              SURGERY SERVICE                        DATE REVIEWED:
                                      FROM: JAN 1,2006  TO: JUN 30,2006              REVIEWED BY:

CASE #              PATIENT                                                              ANESTHESIA TECHNIQUE
OPERATION DATE      OPERATIVE PROCEDURE(S)                                               SURGEON
=============================================================================================================================

SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

63071               SURPATIENT,FOUR  000-17-0555                                         GENERAL
FEB 08, 2006        INGUINAL HERNIA                                                      SURSURGEON,TWO
                    CPT Codes: 49505

63136               SURPATIENT,EIGHT  000-34-5555                                        GENERAL
MAR 07, 2006        CHOLECYSTECTOMY                                                      SURSURGEON,TWO
                    CPT Codes: 47605


TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 2
-----------------------------------------------------------------------------------------------------------------------------
```

Example 5: List of All Major Surgical Cases

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information

Select the Number of the Report Desired: 5

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// N

Print the Report for which Surgical Specialty: GENERAL(OR WHEN NOT
DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)        50


This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

```
                                    ALL MAJOR SURGICAL CASES BY SURGICAL SPECIALTY                              PAGE 1
                                                  MAYBERRY, NC
                                                SURGERY SERVICE                          DATE REVIEWED:
                                          FROM: JAN 1,2006  TO: JUN 30,2006              REVIEWED BY:

CASE #              PATIENT                                  ASSESSMENT STATUS                ANESTHESIA TECHNIQUE
OPERATION DATE      OPERATIVE PROCEDURE(S)                   EXCLUSION CRITERIA               SURGEON
=============================================================================================================================

SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

63110               SURPATIENT,SIXTY  000-56-7821            COMPLETED                        GENERAL
JAN 23, 2006        CHOLEDOCHOTOMY                           SCNR WAS ON A/L                  SURSURGEON,TWO
                    CPT Codes: 47420

63131               SURPATIENT,FIFTYTWO  000-99-8888         NO ASSESSMENT                    GENERAL
APR 21, 2006        PERINEAL WOUND EXPLORATION                                                SURSURGEON,NINE
                    CPT Codes: NOT ENTERED

63136               SURPATIENT,EIGHT  000-34-5555            NO ASSESSMENT                    GENERAL
JUN 07, 2006        CHOLECYSTECTOMY                                                           SURSURGEON,ONE
                    CPT Codes: 47600


TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 3
-----------------------------------------------------------------------------------------------------------------------------
```

Example 6: List of All Surgical Cases

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information

Select the Number of the Report Desired: 6

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>


Print report for ALL specialties ?  YES// N

Print the Report for which Surgical Specialty: 50       GENERAL(OR WHEN NOT DEFINED BELOW)
GENERAL(OR WHEN NOT DEFINED BELOW)        50


This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

ALL SURGICAL CASES BY SURGICAL SPECIALTY PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

CASE # / OPERATION DATE	PATIENT / PRINCIPAL OPERATIVE PROCEDURE	ASSESSMENT STATUS / EXCLUSION CRITERIA	ANESTHESIA TECHNIQUE / SURGEON
SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)			
63110 JAN 23, 2006	SURPATIENT,SIXTY 000-56-7821 CHOLEDOCHOTOMY CPT Code: 47420	COMPLETED SCNR WAS ON A/L	GENERAL SURSURGEON,TWO
63079 APR 02, 2006	SURPATIENT,FIFTYTWO 000-99-8888 INGUINAL HERNIA CPT Codes: NOT ENTERED	INCOMPLETE	GENERAL SURSURGEON,ONE
63131 APR 21, 2006	SURPATIENT,FIFTYTWO 000-99-8888 PERINEAL WOUND EXPLORATION CPT Codes: NOT ENTERED	NO ASSESSMENT	GENERAL SURSURGEON,NINE
63180 JUN 23, 2006	SURPATIENT,SIXTY 000-56-7821 CHOLECYSTECTOMY CPT Codes: 47600	NO ASSESSMENT	NOT ENTERED SURSURGEON,ONE
TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 4			

Example 7: List of Completed/Transmitted Assessments Missing Information

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information

Select the Number of the Report Desired: 7

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>
Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

```
            COMPLETED/TRANSMITTED ASSESSMENTS MISSING INFORMATION       PAGE 1
                              MAYBERRY, NC
                        FROM: JAN 1,2006  TO: JUN 30,2006
                            DATE PRINTED: JUL 13,2006

** GENERAL(OR WHEN NOT DEFINED BELOW)

ASSESSMENT #      PATIENT                              TYPE           STATUS
OPERATION DATE    OPERATION(S)
================================================================================
63172             SURPATIENT,FIFTYTWO  000-99-8888   NON-CARDIAC    TRANSMITTED
MAY 17, 2006      REPAIR ARTERIAL BLEEDING
                  CPT Code: 33120
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.
     2. Anesthesia Technique
--------------------------------------------------------------------------------
63185             SURPATIENT,SIXTEEN 000-11-1111      NON-CARDIAC   TRANSMITTED
APR 17, 2006      INGUINAL HERNIA, CHOLECYSTECTOMY
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.
     2. Concurrent Case
     3. History of COPD (Y/N)
     4. Ventilator Dependent Greater than 48 Hrs (Y/N)
     5. Weight Loss > 10% of Usual Body Weight (Y/N)
     6. Transfusion Greater than 4 RBC Units this Admission (Y/N)
--------------------------------------------------------------------------------
63080             SURPATIENT,THIRTY  000-82-9472      EXCLUDED      COMPLETE
JAN 03, 2006      TURP
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.
     2. Major or Minor


TOTAL FOR GENERAL(OR WHEN NOT DEFINED BELOW): 3

TOTAL FOR ALL SPECIALTIES: 3
```

Example 8: List of Completed/Transmitted Assessments Missing Information

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information

Select the Number of the Report Desired: 8

Start with Date: 6 1 05  (JUN 01, 2005)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>
Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

```
                    1-LINER CASES MISSING INFORMATION               PAGE 1
                                 ALBANY
                    FROM: FEB 27,2006  TO: JUN 7,2006
                         DATE PRINTED: JUN 7,2006

** UROLOGY

CASE #            PATIENT                            TYPE           STATUS
OP DATE           OPERATION(S)
================================================================================

317               SURPATIENT,FOURTEEN 000-45-7212     CARDIAC        COMPLETE
APR 10, 2006      Vasectomy
                  CPT Codes: NOT ENTERED
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.
     2. Attending Code
     3. Wound Classification
     4. ASA Class
--------------------------------------------------------------------------------


TOTAL FOR UROLOGY: 1
```

Print 30 Day Follow-up Letters

[SROA REPRINT LETTERS]

The Surgical Clinical Nurse Reviewer uses the *Print 30 Day Follow-up Letters* option to automatically print a letter, or a batch of letters, addressed to a specific patient or patients.

About the "Do you want to print the letter for a specific assessment?" Prompt

The user responds **YES** to this prompt in order to print a follow-up letter for a single assessment. The software will ask the user to select the patient and case for which the letter will be printed. See Example 1 below.

The user responds **NO** to this prompt if he or she wants to print a batch of follow-up letters for surgical cases within a data range. The software will ask for the beginning and ending dates of the date range for which the letters will be printed. See Example 2 on the following pages.

If the patient has died, the software notifies the user of the death, and will not print the letter. Also, if a patient has not been discharged, the follow up letter will not print.

Example 1: Print a Single Follow-up Letter

```
Select Surgery Risk Assessment Menu Option: F  Print 30 Day Follow-up Letters

Do you want to edit the text of the letter? NO// <Enter>

Do you want to print the letter for a specific assessment ?  YES// <Enter>

Select Patient:      SURPATIENT,NINETEEN     03-03-30     000287354     SC VETERAN

SURPATIENT,NINETEEN 000-28-7354

1. 06-18-06   CORONARY ARTERY BYPASS (INCOMPLETE)

2. 01-25-06   PULMONARY LOBECTOMY (TRANSMITTED)



Select Surgical Case: 1

Print 30 Day Letters on which Device: [Select Print Device]
```

----------*printout follows*----------

NINETEEN SURPATIENT JUL 18, 2006
87 ANY STREET
MT. PILOT, NC 00000

Dear Mr. Surpatient,

One month ago, you had an operation at the VA Medical Center. We are interested in how you feel. Have you had any health problems since your operation ? We would like to hear from you. Please take a few minutes to answer these questions and return this letter in the self-addressed stamped envelope.

Have you been to a hospital or seen a doctor for any reason since your operation ? ___ Yes ___ No

If you answered NO, you do not need to answer any more questions. Please return this sheet in the self-addressed stamped envelope.

If you have answered YES, please answer the following questions.

1) Have you been seen in an outpatient clinic or doctor's office ?
___ Yes ___ No

Why did you go to the clinic or doctor's office ? _____

Where ? (name and location) _____ Date ? _____

Who was your doctor ? _____

2) Were you admitted to a hospital ? ___ Yes ___ No

Why did you go to the hospital ? _____

Where ? (name and location) _____ Date ? _____

Who was your doctor ? _____

Please return this letter whether or not you have had any medical problems. Your health and opinion are important to us. Thank you.

Sincerely,

Surgical Clinical Nurse Reviewer

Monthly Surgical Case Workload Report

[SROA MONTHLY WORKLOAD REPORT]

The *Monthly Surgical Case Workload Report* option generates the Monthly Surgical Case Workload Report that may be printed and/or transmitted to the NSQIP national database. The report can be printed for a specific month, or for a range of months.

Example: Monthly Surgical Case Workload Report – Single Month

```
Select Surgery Risk Assessment Menu Option: M  Monthly Surgical Case Workload Report

Report of Monthly Case Workload Totals

Print which report?

1. Report for Single Month
2. Report for Range of Months

Select Number (1 or 2): 1//  <Enter>

This option provides a report of the monthly risk assessment surgical case
workload totals which include the following categories:
     1. All cases performed
     2. Excluded cases
     3. Assessed cases
     4. Non-assessed cases
     5. Cardiac cases
     6. Non-cardiac cases
     7. Assessed cases per day (based on 20 days/month)

The second part of this report provides the total number of incomplete
assessments remaining for the month selected and the prior 12 months.

Compile workload totals for which month and year? MAY 2006//  <Enter>

Do you want to print all divisions? YES//  <Enter>

This report may be printed and/or transmitted to the national database.

Do you want this report to be transmitted to the central database? NO// <Enter>

Print report on which Device: [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC
REPORT OF MONTHLY SURGICAL CASE WORKLOAD
FOR MAY 2006

TOTAL CASES PERFORMED	=	249
TOTAL MAJOR CASES	=	227
TOTAL MINOR CASES	=	22
CASES MEETING EXCLUSION CRITERIA	=	114
ANESTHESIA TYPE	=	55
EXCEEDS MAX. ASSESSMENTS	=	0
EXCEEDS MAXIMUM TURPS	=	0
STUDY CRITERIA	=	59
SCNR WAS ON A/L	=	0
CONCURRENT CASE	=	0
EXCEEDS MAXIMUM HERNIAS	=	0
ASSESSED CASES	=	135
NOT LOGGED MAJOR CASES	=	0
CARDIAC CASES	=	16
NON-CARDIAC CASES	=	119
ASSESSED CASES PER DAY	=	6.75

NUMBER OF INCOMPLETE ASSESSMENTS REMAINING FOR PAST YEAR

	CARDIAC	NON-CARDIAC	TOTAL
MAY 2005	0	0	0
JUN 2005	0	0	0
JUL 2005	0	0	0
AUG 2005	0	0	0
SEP 2005	0	0	0
OCT 2005	0	0	0
NOV 2005	0	0	0
DEC 2005	0	0	0
JAN 2006	0	0	0
FEB 2006	0	0	0
MAR 2006	0	0	0
APR 2006	0	0	0
MAY 2006	15	82	97
	15	82	97

Example: Monthly Surgical Case Workload Report – Range of Months

```
Select Surgery Risk Assessment Menu Option: M  Monthly Surgical Case Workload Report

Report of Monthly Case Workload Totals

Print which report?

1. Report for Single Month
2. Report for Range of Months

Select Number (1 or 2): 1//  2

Start with which month and year? OCT 2005//   (OCT 2005)  <Enter>

End with which month and year? MAY 2006//   (MAY 2006)  <Enter>

Do you want to print all divisions? YES//  <Enter>

Print report on which Device: [Select Print Device]
```

----------*printout follows*----------

```
            ALBANY - ALL DIVISIONS
         REPORT OF SURGICAL CASE WORKLOAD
          FOR OCT 2005 THROUGH MAY 2006
-------------------------------------------------
    TOTAL CASES PERFORMED             =    30
        TOTAL MAJOR CASES             =     5
        TOTAL MINOR CASES             =    25
    CASES MEETING EXCLUSION CRITERIA  =     1
        NON-SURGEON CASE              =     0
        ANESTHESIA TYPE               =     0
        EXCEEDS MAX. ASSESSMENTS      =     0
        EXCEEDS MAXIMUM TURPS         =     0
        STUDY CRITERIA                =     0
        SCNR WAS ON A/L               =     1
        CONCURRENT CASE               =     0
        EXCEEDS MAXIMUM HERNIAS       =     0
    ASSESSED CASES                    =    20
    NOT LOGGED MAJOR CASES            =     0
    CARDIAC CASES                     =     4
    NON-CARDIAC CASES                 =    16
-------------------------------------------------
```